

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2130

CERTIFICATE OF DEATH

Reg. Dist. No.

W2086

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Bethesda 184 days		a. STATE Maryland	b. COUNTY Anne Arundel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo				
3. NAME OF DECEASED (Type or print)		First Ruthe	Middle Alice	Last Abner	4. DATE OF DEATH February 8 1958			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1901	9. AGE (In years from birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Philanthropic		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Frederick Potter				14. MOTHER'S MAIDEN NAME May Coulter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 577-30-5401		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the cervix with DUE TO (c) Metastasis to pelvis, liver and lungs. 20 mos								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 wk.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____		August 8, 1957, to February 8, 1958, that I last saw the deceased alive on February 8, 1958, and that death occurred at 10:10A.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE Charles F. Nadler, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland						
DATE SIGNED 2/9/58								
PHYSICIAN'S NAME (Type) Charles F. Nadler, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-58		22c. NAME OF CEMETERY OR CREMATORIAL Nat. Mem. Park		22d. LOCATION (City/town, or county) Tall Church		
23. FUNERAL DIRECTOR'S SIGNATURE Tall Funeral Home Wash. DC		ADDRESS		24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE Auerbach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

BUREAU V. S.

FEB 12 1958

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMA. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cedarcroft San.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ralston	Middle H.	4. DATE OF DEATH Feb. 17, 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/1919
9. AGE (In years from birthday) 38 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician	11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Leason H. Adams	14. MOTHER'S MAIDEN NAME Jeanette Blaisdell	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Passive congestion of lungs, liver, spleen (c) and kidneys			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 2/17/58	
EXAMINER'S NAME (Type) Frank J. Broschart			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Mall	22d. LOCATION (City, town, or county) (State) Arb. Va
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Huntman & Son</i>	ADDRESS 5732 Malone	24a. REC'D BY REGISTRAR FEB 21 '58	24b. REGISTRAR'S SIGNATURE <i>W. H. Huntman</i>
V5. A15ME 5M 2/57			

BUREAU Y. S.

FEB 21 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2132 CERTIFICATE OF DEATH

Reg. Dist. No. 02088

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		Maryland		b. COUNTY	
Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - Silver Spring		hacutgameay	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STREET ADDRESS		19 yrs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Rural - Silver Spring		19 yrs		d. STREET ADDRESS		10406 Rodney Rd			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		10406 Rodney Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Margaret Ann Albright					Feb	24	1958		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Fe	Cauc.			Nov. 28, 1874	83 yrs	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own home		Ohio		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Peter Weaver		Hulda Sherrits							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		none		Celestine Adams (dtr)		10406 Rodney Rd-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH				
		422.1			20 yrs				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
None									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from July 1956 to Feb 24, 1958, that I last saw the deceased alive on Feb 23, 1958, and that death occurred at 2:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE JAMES M. WHITLOCK M.D. ADDRESS (Street, city or town, state) 7701 Carroll Ave DATE SIGNED 2-24-58									
PHYSICIAN'S NAME (Type)		JAMES M. WHITLOCK Takoma Park 12nd							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORIUM COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wesuer E. Pumphrey,		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 26 '58		24b. REGISTRAR'S SIGNATURE Ques. 11			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEBT

RECEIVED

BUREAU V.
RECEIVED
FEB 26 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2133 CERTIFICATE OF DEATH

02089

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

92 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

The Clinical Center, Bethesda 14, Md.

3. NAME OF
DECEASED
(Type or print)First
RobertMiddle
WhitmanLast
Annis4. DATE
OF
DEATHMonth
FebruaryDay
15Year
1958

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

December 20, 1927

9. AGE (In years
last birthday)

30 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pharmacist

11. KIND OF BUSINESS OR INDUSTRY

Pharmacy

12. BIRTHPLACE (State or foreign country)

Illinois

13. CITIZEN OF WHAT COUNTRY?

U. S. A.

14. FATHER'S NAME

Russell Annis

15. MOTHER'S MAIDEN NAME

Gladys Hart

16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

No

17. SOCIAL SECURITY NO.

Un 298-22-5225

18. INFORMANT

The Medical Record

Address

The Clinical Center, Bethesda 14, Maryland

19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Necrotizing Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

3 weeks

344X

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

Hydrocephalus & Chronic Meningitis due

to Candida albicans

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I attended the deceased from November 15, 1957, to February 15, 1958, that I last saw the deceased alive on February 15, 1958, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Bayard Tynes M.D.

The Clinical Center

2/16/58

PHYSICIAN'S
NAME (Type)

Bayard Tynes, M. D.

National Institutes of Health
Bethesda 14, Maryland22a. BURIAL, CREMATION,
REMOVAL (Specify)

removal

22b. DATE THEREOF

2/17/58

22c. NAME OF CEMETERY OR CREMATORIUM

Holy Cross Cemetery

22d. LOCATION (City, town, or county)

Brook Park, Ohio

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co.

ADDRESS

2901 14th St. N.W.
Washington, D.C.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

FEB 19 '58

Audited

WILSON'S STATIONERY & BOOKSTORE, INC.
CERTIFICATE OF DEATH

BUREAU V.
RECEIVED
FEB 19 1950

02690

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2134	MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?				
Bethesda		1 hour		Bethesda, R.F.D. #3		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/d. STREET ADDRESS		P.O. Box 620						
Suburban Hospital										
3. NAME OF DECEASED (Type or print)		First Bernice	Middle 	Last Anthony	4. DATE OF DEATH	Month February	Day 12	Year 1958		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Female		Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 25, 1918	39 yrs.	Months	Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Housewife		---		Maryland, Montgomery County		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Henry Sheild		Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
---		None		Fred Anthony-Husband		Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Pulmonary Edema				2 hours				
422.2 Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Acute Congestive Heart Failure				2 hours				
		DUE TO (c) Myocardial Insufficiency				2 hours				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Frank J. Brachert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-12-58				
EXAMINER'S NAME (Type) <i>Frank J. Brachert</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National.,	22d. LOCATION (City, town, or county) Arlington, Va.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Snowden, Rockville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 21 '58	24b. REGISTRAR'S SIGNATURE <i>Albert E. ...</i>					

WISCONSIN STATE MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU U. S.

FEB 21 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2135 CERTIFICATE OF DEATH

Reg. Dist. No.

102091

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Bethesda 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Washington 412 E 21st St 2400 16th Street, N.W. #529	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Henryk	Middle	Last Arctowski	4. DATE OF DEATH February 21	Month Day	Year 1958
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1871	9. AGE (in years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY Physcist		11. BIRTHPLACE (State or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A. 1915	
13. FATHER'S NAME Karol Arctowski		14. MOTHER'S MAIDEN NAME Sofie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 491X		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records		2400 16th St. N.W. Jane Arctowski, wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		negative heart failure				INTERVAL BETWEEN ONSET AND DEATH 4 days	
		Bronchopneumonia				4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nremia.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Feb 1958, to 21 Feb 1958, that I last saw the deceased alive on 20 Feb 1958, and that death occurred at 4:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE SERUCH T. KIMBLE, M.D. M.D. 929 PERSHING DR., SILVER SPRING, MD PHYSICIAN'S NAME (Type) 21 FEB 58						DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE SERUCH	
The S. R. Kinne Co. 2901 14th St. NW							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K-5

3-4 1958

K-5
SEARCHED
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FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2136 CERTIFICATE OF DEATH

112092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>		d. STREET ADDRESS <u>5043 Bradley Blvd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>PATRICIA</u>	Middle <u>Ann</u>	Last <u>Ault</u>	4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>10</u> Year <u>1958</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1958</u>	9. AGE (In years lost birthday) yrs. <u>25</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Not Given</u>			14. MOTHER'S MAIDEN NAME <u>BETTY JANE COX</u>		Address <u>MOTHER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Hydrocephalus		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beckerda</u>		20f. (City or town) <u>Beckerda</u> (County) <u>Montgomery</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>1/17</u> , 19 <u>58</u> , to <u>2/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>58</u> , and that death occurred at <u>120</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.H. Mitchell</u>				ADDRESS (Street, city or town, state) <u>8215 Wisconsin Ave</u>		DATE SIGNED <u>10 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>R.H. MITCHELL MD</u>		16 Bethesda Rd					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/13/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>MT. COMFORT CEMETERY</u>		22d. LOCATION (City, town, or county) <u>FAIRFAX CO. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Early</u>				ADDRESS <u>809 King St., Alexandria, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TEAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2137 CERTIFICATE OF DEATH

102093

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>22 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pinkville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>McCourtan</i>		d. STREET ADDRESS <i>1515 Elmgrove DRIVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LOLA EMMA BARKER		First	Middle	Last	4. DATE OF DEATH 2	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-11-81</i>	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Walker Louisiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John James</i>		14. MOTHER'S MAIDEN NAME <i>? REBECCA</i>		Address <i>Daughter Ette Campbell 1324 Rockville</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO <i>-</i>		17. INFORMANT <i>Daughter Ette Campbell</i>		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Congestive heart failure</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Atherosclerotic heart disease</i>		20 yrs.				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5707 Wisconsin Ave</i>		20f. (City or town) <i>Cherry Chase</i>		(County) <i>Maryland</i> (State) <i>MD</i>
21. I certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>February</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>February 2</i> , 19 <i>58</i> , and that death occurred at <i>7:05 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Donald O. Ekman</i>		M.D.		ADDRESS (Street, city or town, state) <i>5707 Wisconsin Ave</i>		DATE, SIGNED <i>5/2/58</i>		
PHYSICIAN'S NAME (Type) <i>DONALD O EKMAN</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2-8-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>3072 M-ST-W</i>		22d. LOCATION (City, town or county) <i>HOT SPRINGS</i>		(State) <i>ARKANSAS</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chamberlain</i>		ADDRESS <i>3072 M-ST-W</i>		24a. REC'D BY REGISTRAR FEB 6 '58		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>		

BUREAU V. S.

FEB 6 1968

KALIFORNIA V. GALT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112094

Item 18 Film 225 2-19-58 ams

2138

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 23 hours		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE District of Columbia		b. COUNTY		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 613 "M" Street, N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lula Hester		First Middle Lula Hester		Last BARRETT		4. DATE OF DEATH February 2 1958		Month February	Doy 2	Year 1958
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1928		9. AGE (In years last birthday) 29 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY U.S.				
13. FATHER'S NAME Channings WINES		14. MOTHER'S MAIDEN NAME Martha MEHAFFIE								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT (Husband) Harold D. BARRETT (Same As #2)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Bilateral pneumonia (diplococcus pneumoniae) 48 hours (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 hours										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lupus erythematosus disseminata; long term steroid therapy								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1 February 1958 to 2 February 1958 , that I last saw the deceased alive on 2 February 1958 , and that death occurred at 9:40A.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>F.S. Caldwell</i>						M.D. U.S. Naval Hospital, Bethesda, Md. 2-3-58				
PHYSICIAN'S NAME (Type) F.S. CALDWELL, LT, MC, USN						U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Mattingly, 131 11th St. S.E. Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR FFB 6 5		24b. REGISTRAR'S SIGNATURE <i>A. Leach</i>				

BALTIMORE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2097

CERTIFICATE OF DEATH

Reg. Dist. No.

112095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <i>Montgomery Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE <i>MD.</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville Park</i>		c. LENGTH OF STAY IN 1b <i>18 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Conv. & Hosp.</i>		d. STREET ADDRESS <i>1911 W. Georgia Rd., Silver Spring, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Naomi Myrtle Brown</i>		First: _____	Middle: _____	Last: _____	4. DATE OF DEATH <i>Feb. 7, 1958</i>	Month: _____	Day: _____	Year: _____ <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-12-05</i>	9. AGE (In years last birthday) <i>52 yrs</i>	10. IF UNDER 1 YEAR Months: _____	11. IF UNDER 24 HRS Days: _____ Hours: _____ Min: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>		
13. FATHER'S NAME <i>William Phillips</i>		14. MOTHER'S MAIDEN NAME <i>Florence Belcher</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO <i>no 578-34-0338</i>		17. INFORMANT <i>Charl</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. <i>(b) due to metastases to liver and peritoneum</i> (c)		
						INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>April</i> , 1957, to <i>February 7, 1958</i> , that I last saw the deceased alive on <i>February 7, 1958</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8237 Georgia Ave., Silver Spring, Md.</i>						
ACTUAL SIGNATURE <i>Aaron H. Traum</i>		DATE SIGNED <i>Feb. 11, 1958</i>						
PHYSICIAN'S NAME (Type) <i>AARON H. TRAUM</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2/11/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>		

BUREAU V. S

FEB 11 1963

U.S. GOVERNMENT PRINTING OFFICE: 1963 6-1250-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12096)

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 714 Lenwood Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
f. STREET ADDRESS 714 Lenwood Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Elizabeth Bell		4. DATE OF DEATH Feb. 21, 1958	Month Feb. Day 21 Year 1958
5. SEX female	6. COLOR OR RACE ool.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1895
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years from birthday) 62 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Russell		14. MOTHER'S MAIDEN NAME Elizabeth Murray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	17. INFORMANT Address Mary Bell Same as Item 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aute congestive heart failure DUE TO 46 Conditions, if any, which gave rise to immediate cause (b) Upper Resp. Infection DUE TO 46 (c) 46 DUE TO 46			
INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Feb. 23, 1958
EXAMINER'S NAME (Type) Frank J. Broschart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul,	22d. LOCATION (City, town, or county) Sugarland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swindle</i>		ADDRESS Rookville, Md.	24a. REC'D BY REGISTRAR DATE MAR 3 '58
			24b. REGISTRAR'S SIGNATURE <i>Allie Schaeffer</i>

EUREAU V. S

MR. S. J. C.

U.S. GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12097

2098 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITALS: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>	
d. LENGTH OF STAY IN lb <i>1 year</i>		d. STREET ADDRESS <i>7104 Sycamore Ave</i>	
e. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7104 Sycamore Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FREDERICK FRANCIS BELLMUND, JR.</i>		First	Middle
		Lost	4. DATE OF DEATH <i>Feb 11 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Feb 12, 1957</i>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs <i>11 29</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Jakoma Park, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fredrick F. Bellmund</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Briscoe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Mr. Frederick F. Bellmund (same as #2)</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspirin</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Overdose</i> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>21 Mar</i> , 1957, to <i>11 Feb</i> , 1958, that I last saw the deceased alive on <i>9 Feb</i> , 1958, and that death occurred at <i>8 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.P. Mueller</i>		ADDRESS (Street, city or town, state) <i>M.D. 7112 Willow Ave Jakoma Park Md.</i>	
PHYSICIAN'S NAME (Type) <i>H B Queen</i>		DATE SIGNED <i>11 Feb 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 13, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Wallis, 254 Carroll St N.W. DC</i>		24a. REC'D BY REGISTRAR <i>FEB 13 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>	
		DATE	

BURGESS

EE3 10 1973

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2139

CERTIFICATE OF DEATH

02098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 2402 Lindell Street	
3. NAME OF DECEASED (Type or print) ROBERTA		First V.	Middle BEVLIN
4. DATE OF DEATH 2 16 19 58		Month 2	Day 16
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-20-98		9. AGE (In years lost birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN B. PARKER		14. MOTHER'S MAIDEN NAME MARY F. WYNKOOP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT KENNETH P. VENABLE Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary thrombosis Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (b) DUE TO Coronary insufficiency (c) DUE TO Coronary sclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 year 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1957 to Feb 16, 1958 , that I last saw the deceased alive on 2/16/58 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) D.B. Washington, M.D. 6234 3rd Ave NW, Wash. DC 20007	
ACTUAL SIGNATURE D. B. Washington, M.D.		DATE SIGNED 2/16/58	
PHYSICIAN'S NAME (Type) D. B. Washington, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-58	
22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821 14th St. N.W.	24a. REC'D BY REGISTRAR Feb. 21 58
			24b. REGISTRAR'S SIGNATURE W. B. Edwards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU N.Y.

E3 PA 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12099

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in my office, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2124		3. NAME OF		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
a. COUNTY		MARYLAND		First		Middle		Lost		Male white		Never married		Widowed		Divorced		46 yrs		markman		auto		md		S. S. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rockville		c. LENGTH OF STAY IN lb		9 m		d. STREET ADDRESS		1 S03 Beach Ave		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		503 Beach Ave																									
e. NAME OR PRINT		Earl Edmund Bolton																									
f. FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		1958		IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months		Days		Hours		Min.								Months		Days											
1		2		4		58								1		2		3									
13. FATHER'S NAME		Lewis Bolton		14. MOTHER'S MAIDEN NAME		Unknown		Address																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tell no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)																			
(If yes, give no. or dates of service)		710		577-10-8104		Clarence E. Butt - R-1 - Rockville md		INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		DUE TO		Coronary occlusion		4 hrs.																					
420.1																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO																							
				(c)																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)																									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)															
Hour o. m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE		FRANK J. Boosch		21. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED															
EXAMINER'S NAME (Type)												2-1-58															
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)																					
Burial		2/8/58		Parklawn		Rockville, Maryland																					
23. FUNERAL DIRECTOR'S SIGNATURE								24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE																	
Robert A. Pumphrey-Bethesda, Md.								FEB 6 '58		D. L. Smith																	
VS. A15ME																											
5M 2/57																											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2140

CERTIFICATE OF DEATH

02100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ashton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH February 10 1958	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/16/84	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR / IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Lewis Bond		14. MOTHER'S MAIDEN NAME Rachael Bond						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Annie Bond		Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		acute Pulmonary Edema				INTERVAL BETWEEN ONSET AND DEATH 4 days		
Barkward cardiac Failure						5 yrs		
Acute Insuff.						15 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 6-5-1953 , to 10 Feb 1958 , that I last saw the deceased alive on 10 Feb 1958 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.								
						ADDRESS (Street, city or town, state)		DATE SIGNED 11/15/58
ACTUAL SIGNATURE John B. Ziegler, M.D.								
NAME (Type) John B. Ziegler, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 2-14-58		22c. NAME OF CEMETERY OR CREMATORIUM Ash NEMORIN 1		22d. LOCATION (City, town, or county) SANDY SPRING		(State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Gueroddy		ADDRESS Rockville, Md.		24a. REC'D. BY REGISTRAR FEB 20 1958		24b. REGISTRAR'S SIGNATURE Alt. Reduch		

GEORGE V. E

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2141

CERTIFICATE OF DEATH

Reg. Dist. No.

02101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
COR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be shred with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Ca.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			b. COUNTY <i>Sheppard</i>		
c. LENGTH OF STAY IN lb <i>17 hours</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>			d. STREET ADDRESS <i>K7D #1</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First <i>George</i> Middle <i>Luther</i> Last <i>Bain</i>			4. DATE OF DEATH Month <i>Feb.</i> Day <i>26</i> Year <i>1958</i>		
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 5, 1879</i>	9. AGE (In years last birthday) <i>78 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		
11. BIRTHPLACE (State or Foreign country) <i>Shenandoah County, Va</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>Perry J. Brill</i>			14. MOTHER'S MAIDEN NAME <i>Orndoff</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. INFORMANT <i>Son</i> Address <i>4506 Grand St., Rockville, Md.</i>		
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X</i> DUE TO <i>Cerebral edema with increased intracranial pressure</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Irritability</i> (c) <i>Arteriosclerotic kidney disease</i>			days <i>0</i> years <i>0</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Heart Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>February 25, 1958</i> , to <i>February 26, 1958</i> , that I last saw the deceased alive on <i>February 25, 1958</i> , and that death occurred at <i>6:55 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Aaron H. Traum</i>			ADDRESS (Street, city or town, state) <i>M.D. 8237 Georgia Ave., Silver Spring, Md. 20910</i>		
PHYSICIAN'S NAME (Type)			DATE SIGNED <i>4/26/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bury</i>		22b. DATE THEREOF <i>2-28-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Massachusetts</i>	
22d. LOCATION (City, town, or county) <i>Edinburg</i>		(State) <i>Va</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>D.H. Cucklerbough or Vienna, Va.</i>			24a. REC'D BY REGISTRAR <i>Date 3 '58</i>		
			24b. REGISTRAR'S SIGNATURE <i>Alv. Lee</i>		

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2142 CERTIFICATE OF DEATH

Reg. Dist. No 12102

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>1416 - Saratoga Ave.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home of Rest Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i>		First	Middle	Last	4. DATE OF DEATH <i>February 25th, 1958</i>	Month	Day	Year	
S SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 1st 1866</i>	9 AGE (In years lost birthday) yrs <i>92</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John T Brinkley</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Martin.</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>		17. INFORMANT <i>Edna Beck - Washington D.C.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerotic heart disease</i>		DUE TO <i>Generalized arteriosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Washington D.C.</i>	(County) <i>(State)</i> <i>(State)</i>		
21. I certify that I attended the deceased from <i>Feb 19, 1958</i> , to <i>Feb 25, 1958</i> that I last saw the deceased alive on <i>Feb 24, 1958</i> , and that death occurred at <i>12-13 M</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Wash D.C.</i>					
ACTUAL SIGNATURE <i>M. E. Cittman</i>		M.D. <i>420-1866-421-11-25-58</i>		DATE SIGNED <i>2/25/58</i>					
PHYSICIAN'S NAME (Type) <i>M. E. Cittman</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 28, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Congressional</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Washington D.C.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. P. edie</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Lines 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU Y. S

118

REGISTRATION
NUMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2143 CERTIFICATE OF DEATH

Reg. Dist. No. 2103

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4808 Leland Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frank	Middle Benjamin	Last Brouner
4. DATE OF DEATH	Month February	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 9, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head Clerk		10b. KIND OF BUSINESS OR INDUSTRY Southern Railway	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Neff Brouner		14. MOTHER'S MAIDEN NAME Catherine Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-10-5673	
17. INFORMANT Lola V. Brouner-wife		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO _____ (c) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH 28 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia, bronchiectasis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 491X	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 860 old Georgetown Rd		20f. (City or town) Suitland, Maryland (County) Maryland (State)	
21. I certify that I attended the deceased from 3/25/58 to Feb 6, 1958 that I last saw the deceased alive on Feb 6, 1958 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Allen J. O'Neill		ADDRESS (Street, city or town, state) 860 old Georgetown Rd	
DATE SIGNED 1958			
PHYSICIAN'S NAME (Type) Allen J. O'Neill MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/58	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
		24b. REGISTRAR'S SIGNATURE Clifford E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be revised by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12194)

Reg. Dist. No.

2144

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 00A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 7036 STRATHMORE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cheryl		First Cheryl	Middle ARLENE	Last Brown	4. DATE OF DEATH Feb 18 1958	Month Feb	Day 18	Year 1958

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN 12, 1958	9. AGE (In years last birthday) 1 yr.	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 12	Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME William E Brown	14. MOTHER'S MAIDEN NAME Lois Kerr	Address Same Item #2
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Father

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		Pulmonary edema Upper Respiratory Infection 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
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ACTUAL SIGNATURE <i>Frank J. Boschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>2-18-58</i>		
EXAMINER'S NAME (Type) FRANK J. BOSCHART M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/19/1958	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Rockville	(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md	ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md	24a. REC'D. BY REGISTRAR FEB 21 '58	24b. REGISTRAR'S SIGNATURE <i>John Allen</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)
5M 9/55

Y. V. MUSICO



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12105

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived)		f. INSTITUTION: Residence before admission			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland		b. COUNTY Montg.			
Olney		life		X Olney					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
Stanley M. Brown					Feb. 17, 1958				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)			10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 24 1904	53 yrs	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, in detail)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
laborer		Driver Retail Grocery		id.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Henry S. Brown		Maud A. Johnson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes, give war or dates of service)		577.05.4051		Wife		Same As 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sudden							
44		Coronary occlusion							
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
{ (b)									
DUE TO									
{ (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		<i>Frank J. Broschart</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)			(State)	
Burial		2/22/58	Salem Methodist		Brookeville, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>Ray W Barber</i>		Laytneville, Md.		DATE FEB 20 1958		Signature			

RECORDED
FEB 1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2146 CERTIFICATE OF DEATH

12106
215

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived) b. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 hr. 55min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		First Keith	Middle BRUEGGENJOHANN
4. DATE OF DEATH February 14 1958		Month February	Day 14
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 13 February 1958		9. AGE (In years from birthday) yrs. 4	10. IF UNDER 1 YEAR Months 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME Robert H. BRUEGGENJOHANN	
14. MOTHER'S MAIDEN NAME Mary Ruffner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) R.H. Brueggenjohann (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Respiratory Insufficiency</i> DUE TO (c) <i>Fetal Allectasis</i> DUE TO (d) <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH 4' 55"	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 February, 1958 , to 14 February, 1958 , that I last saw the deceased alive on 14 February, 1958 , and that death occurred at 12:55 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Adam T. Thorp Jr.</i> M.D. U.S. Naval Hospital, Bethesda, Md. 2-14-58			
PHYSICIAN'S NAME (Type) Adam T. Thorp, Jr. LT MC USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 2-18-58	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR FEB 13 '58	
ADDRESS 17725-1		24b. REGISTRAR'S SIGNATURE <i>G. L. Smith</i>	

EDWARD V. S.

8



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2125 CERTIFICATE OF DEATH

02197

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY Montgomery County				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				b. COUNTY Montgomery					
c. LENGTH OF STAY IN lb 5 Stanley Ct.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Stanley Ct.				d. STREET ADDRESS 5 Stanley Court					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First James	Middle Gordon	Last Bryant, Jr.	4. DATE OF DEATH	Month February	Day 1	Year 1958	
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/16	9. AGE (In years last birthday) 41	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective			10b. KIND OF BUSINESS OR INDUSTRY Police			11. BIRTHPLACE (State or foreign country) Washington, D. C.			
13. FATHER'S NAME James Gordon Bryant, Sr.				14. MOTHER'S MAIDEN NAME Mable Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Wife-Mary Bryant			Address 5 Stanley Court
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction									INTERVAL BETWEEN ONSET AND DEATH ? 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterio sclerotic heart disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic alcoholism									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 809 Viers Mill Road		20f. (City or town) Rockville		(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from Sept. 23, 1957, to Feb. 1, 1958, that I last saw the deceased alive on Jan. 29, 1958, and that death occurred at M , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 809 Viers Mill Road									
DATE SIGNED 2/1/58									
<p>ACTUAL SIGNATURE <i>Herman C. Maganzini</i> M.D.</p> <p>PHYSICIAN'S NAME (Type) Herman C. Maganzini</p>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/58		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		22d. LOCATION (City, town, or county) Prince George Co. Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D. 02/04/58		24b. REGISTRAR'S SIGNATURE 02/04/58			

SURÉAU V. S

REGÉVÉE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

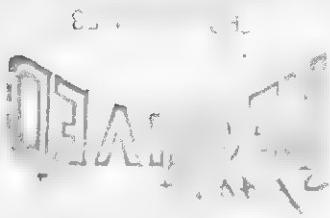
2147 CERTIFICATE OF DEATH

Reg. Dist. No.

02198

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE Virginia		b. COUNTY Carolina	
b. C. T Y OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 60 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparta			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ruby	Middle Esther	Last Bullock	4. DATE OF DEATH February 17, 1958	Month February	Day 17	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1918	9. AGE (In years less birthday) 39 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Loving				14. MOTHER'S MAIDEN NAME Bertie Tucker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 229-16-8729		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) Urteral obstruction from metastases DUE TO (c) Carcinoma of the stomach INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19 1957 to February 17, 1958 , that I last saw the deceased alive on February 17, 1958 , and that death occurred at 5:17 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2/18/58 DATE SIGNED							
ACTUAL SIGNATURE Donald M. Watkins M.D. The Clinical Center PHYSICIAN'S NAME (Type) National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL CREMATION, REMOVED (Specify) BURIAL		22b. DATE THEREOF 2-20-58		22c. NAME OF CEMETERY OR CREMATORIUM SALEM BAPTIST CHURCH		22d. LOCATION (City, town, or county) (State) SPARTA, VA	
23. FUNERAL DIRECTOR'S SIGNATURE V. S. Evelyn		ADDRESS Alexandria, Va.		24a. REC'D BY REGISTRAR DATE FEB 21 1958		24b. REGISTRAR'S SIGNATURE W. E. Eddison	

BUNEAU V. E.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2148 CERTIFICATE OF DEATH

02109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>Suburban</i>	b. COUNTY <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4333 Wisconsin Ave., N.W.</i>		d. STREET ADDRESS <i>4333 Wisconsin Ave., N.W.</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Josephine E. Burrows</i>	First <i>Josephine</i>	Middle <i>E.</i>	Last <i>Burrows</i>
4. DATE OF DEATH <i>2 14 1958</i>	Month <i>2</i>	Day <i>14</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>June 15 1876 81</i>	9. AGE (In years last birthday) yrs. <i>77</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Malone</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret McNamee</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Son - Malcolm A. Burrows</i>	Address <i>8809 Kenilworth Rd. Bethesda, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>25 days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Armenia</i> 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO <i>generalized arteriosclerosis</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerotic heart disease with congestive heart failure</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Feb</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>19</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I attended the deceased from <i>Feb 13, 1958</i> , to <i>Feb 14, 1958</i> , that I last saw the deceased alive on <i>Feb 13, 1958</i> , and that death occurred at <i>546 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilfred R. Ehrmantrout, M.D.</i>		ADDRESS (Street, city or town, state) <i>4890 Battery Lane, Bethesda, Md. 20814</i>	
PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmantrout, M.D.</i>		DATE SIGNED <i>2/17/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/17/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Dunland Rd. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i>	ADDRESS <i>5703 Wisconsin Ave., Wash. DC</i>	REC'D BY REGISTRAR DATE <i>FEB 20 '58</i>	24. REGISTRAR'S SIGNATURE <i>Albert L. Reich</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2149

CERTIFICATE OF DEATH

02110

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) ■ STATE Maryland		b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 317 Leighton Ave.,		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kate	Middle Isabel	Last BUSCALL	4. DATE OF DEATH February 20 1958	Month Year	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 August 1882	9. AGE (In years last birthday) 75 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME George Lippert				14. MOTHER'S MAIDEN NAME Alice V. Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Husband) David C. Buscall (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic adenocarcinoma, abdomen. INTERVAL BETWEEN ONSET AND DEATH 3 mo. +							
151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Adenocarcinoma, Stomach		(c)		3 mo. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 February, 1958 to 20 February, 1958 that I last saw the deceased alive on 20 February, 1958 , and that death occurred at 8:25A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-20-58							
ACTUAL SIGNATURE <i>Burt C. Johnson</i> M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) Burt C. Johnson, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey, 8434 Georgia Ave. Silver Spring, Md.				ADDRESS		24a. REC'D BY REGISTRAR FEB 24 '58	
24b. REGISTRAR'S SIGNATURE <i>John E. Johnson</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2150

CERTIFICATE OF DEATH

02111

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 3515 Briggs Chaney			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Nunnally		First	Middle	Last	4. DATE OF DEATH February 3 1958	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 February 1908	9. AGE (in years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Charles CHASE			14. MOTHER'S MAIDEN NAME Zelia NUNNALLY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I unknown		17. INFORMANT (Sister) Louise Chase RIGGAN		Address Silver Spring, Md. 8712 Colesville Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction, myocardium</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH unknown									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Arlington	(State) Virginia
21. I certify that I attended the deceased from 15 January 1958 , to 3 February 1958 that I last saw the deceased alive on 3 February 1958 , and that death occurred at 4:20A M. from the causes and on the date stated above									
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.									
DATE SIGNED C. U. Shilling									
ACTUAL SIGNATURE C. U. Shilling		M.D. U.S. Naval Hospital, Bethesda Md.							
PHYSICIAN'S NAME (Type) C. U. SHILLING LT MC USN		U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington			
						(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Pumphrey		ADDRESS 8434 Georgia Ave. Silver Spring Md.		24a. REC'D BY REGISTRAR FEB 6 '58		24b. REGISTRAR'S SIGNATURE Al. Lewis			

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2151

CERTIFICATE OF DEATH

02112

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN lb 53 years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5905 Bradley Boulevard		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5905 Bradley Boulevard						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Julia		First	Middle	Last	4. DATE OF DEATH COX	Month February	Day 26	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1888		9. AGE (In years lost birthday) 70 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Gastaldo		14. MOTHER'S MAIDEN NAME Maria ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Marie Philpott-Same Item #2-Niece		Address		
18. CAUSE OF DEATH [Enter only one cause, one line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x		Pulmonary Embolism				INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Cerebral embolism	DUE TO (c)			6 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 9/12/58 , 19, to 9/26/58 , 19, that I last saw the deceased alive on 9/24/58 , 19, and that death occurred at M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>James A. O'Keefe, M.D.</i>				M.D. 4545 Conn. Ave. N. W.		February 26, 1958		
PHYSICIAN'S NAME (Type) James A. O'Keefe, M. D.				Washington, D. C.				
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		22d. LOCATION (City, town, or county) Prince George Co., Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR Mar 3 '58		24b. REGISTRAR'S SIGNATURE <i>John research</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2152

CERTIFICATE OF DEATH

Reg. Dist. No.

02113

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESMOR NURSING HOME		d. STREET ADDRESS 4207 Rosemary Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle PARKER	Last CRABBE	4. DATE OF DEATH 2 15 1958	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/26/1876	9. AGE (in years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Parker		14. MOTHER'S MAIDEN NAME Sarah Crabbe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT Dale F. Snell- 4619 Langdrum Lane Chevy Chase, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Advanced arteriosclerosis, general		Address 3 hrs.			
(b) DUE TO Bronchopneumonia, acute		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
(c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1948, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Stewart Clapp PHYSICIAN'S NAME (Type) Stewart Clapp		M.D. 3921 Ingaman St NW Feb 15 '58		ADDRESS (Street, city or town, state) Wash 15 DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR FEB 19 '58		24b. REGISTRAR'S SIGNATURE Alv. Smith	
VS A15 (4) 15M 9/55					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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2153

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Silver Spring		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 11 Hr. 9min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 8108 Tahona Drive		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mark		First Mark	Middle Saen	Last CUNNINGHAM	4. DATE OF DEATH February 3 1958	Month February	Day 3	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 February 1958	9. AGE (In years last birthday) yrs 11	IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS Days 9	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Thomas Frederick CUNNINGHAM			14. MOTHER'S MAIDEN NAME Helen Maryann QUINN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Thomas F. Cunningham (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) IMMATURITY								
INTERVAL BETWEEN ONSET AND DEATH 11 hrs 9 min								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3 February, 1958 , to 3 February, 1958 , that I last saw the deceased alive on 3 February, 1958 , and that death occurred at 6:00P.M. , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.								
DATE SIGNED 2-5-58								
ACTUAL SIGNATURE <i>Russell Miller Jr.</i>								
PHYSICIAN'S NAME (Type) Russell Miller, 2d LT, MC, USN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-7-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		ADDRESS R. A. Pumphrey, 7657 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR FFB 6 '58		24b. REGISTRAR'S SIGNATURE <i>Deuchi</i>		

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CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14730

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery		b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
Takoma Park		D. District Columbia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Washington Sanitarium & Hosp.		1026 7th Street N.E. D.C.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Milton		B.	A.
Last		4. DATE OF DEATH	
Anderson		Month	Day
		FEBRUARY	8
		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		Blonde	
8. DATE OF BIRTH		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
C. 29 16		44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Businessman		11. BIRTHPLACE (State or foreign country)	
		Anderson, S.C.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frederick Anderson		Terlenia Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address Mr. Frederick Anderson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Shock due to Respiratory Failure	
DUE TO		45 min.	
(b)		Crushed Chest - Bilateral Collapse flings	
DUE TO			
(c)		Auto Injury	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Fracture of pelvis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall while attempting to board truck - Ran over by truck	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 9:42 p.m. 2-6 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
		20f. (City or town) Silver Spring, D.C. (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 2-6-58	
EXAMINER'S NAME (Type) FRANK J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-58	
		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	
		22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Theimer Funeral Home 413-H St. N.E. Wash. D.C.		24a. REC'D BY REGISTRAR	
		DATE APR 9 1958	
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. R.

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REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2154

CERTIFICATE OF DEATH

02115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
Montgomery Maryland		a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Bethesda		b. COUNTY Montgomery	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 1040 Metropolitan Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Dora	Middle Mae
4. DATE OF DEATH		Month 2	Day 6
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 8, 1903		9. AGE (In years from birth day) 34 yrs	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Clarence Chapman		14. MOTHER'S MAIDEN NAME Lilly Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Husband: Wm. George Curtis		Address 1040 1/2 Metropolitan Ave. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intr. crani l Pressure			
DUE TO 10.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Obstructive hydrocephalus DUE TO 1 day	
		(c) Pneumococcic meningitis 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/58, 19, to 2/6/58, 19, that I last saw the deceased alive on 2/1/58, 19, and that death occurred at 2:40 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Kensington, Md. 2/6/58	
ACTUAL SIGNATURE John Allen MD		DATE SIGNED 2/6/58	
PHYSICIAN'S NAME (Type) Sam Allen MD		Kensington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-58	
22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
		24b. REGISTRAR'S SIGNATURE E. J. Murphy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be filled by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2155 CERTIFICATE OF DEATH

02116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 304 South Columbus Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First George	Middle Washington	Last Davidson	4. DATE OF DEATH February 20,	Month 19	Day 58
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1910	9. AGE (In years lost birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aubrey A. Davidson				14. MOTHER'S MAIDEN NAME Cora L. Camben			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mycosis Fungoides INTERVAL BETWEEN ONSET AND DEATH 15 Years. 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 3, 1958, to February 20, 1958, that I last saw the deceased alive on February 20, 1958, and that death occurred at 12:20 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Burkard K. Sleas</i> M.D. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt Comfort		22d. LOCATION (City, town, or county) Fairfax Co., Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home				ADDRESS Alexandria, Virginia		24a. REC'D BY REGISTRAR Date 2-23-58	
24b. REGISTRAR'S SIGNATURE <i>William J. Peoples, M.D.</i>							

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02117

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.												
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)						
						a. STATE	Maryland		b. COUNTY	Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Olney		DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
						Glenelg						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Montgomery County General Hospital										
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year				
Emma		Jean	Deavers		February	14	19	58				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)						10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 13, 1957	yrs. 9 1						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
child		None		Maryland		U.S.A.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
Charles Parham		Sylvia Deavers										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address						
		None		Miss Sylvia Deavers, Glenelg, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		found										
asphyxia												
DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		vomitus aspirated								
DUE TO												
		(c)		upper respiratory infection								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		<i>Frank J. Broschart</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED				
EXAMINER'S NAME (Type)		Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		February 14, 1958				
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
Burial		2-16-58		Liberty Baptist		Lisbon, Md						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
F.C. Higinbotham, Ellicott City, Md						FEB 21 '58						
2069222XV2												

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EB 21 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2157 CERTIFICATE OF DEATH

02118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First Edward	Middle Henderson	Last Deets	4. DATE OF DEATH February 24	Month 24	Day 19	Year 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/87	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 70	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Dr. James E. Deets				14. MOTHER'S MAIDEN NAME Sarah Henderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO WW 1 215-01-4586		17. INFORMANT Nelle Patterson Deets			Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Grnl. arteriosclerosis									INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1953 , 19, to Feb. 24, 1958 , that I last saw the deceased alive on Feb. 24, 1958 , and that death occurred at 2 p.m. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Gaithersburg, Maryland									
DATE SIGNED 2-24-58									
ACTUAL SIGNATURE Jack Schumacher									
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Neelsville Church Cem		22d. LOCATION (City, town, or county) Neelsville, Maryland			
(State)									
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey									
ADDRESS Bethesda, Maryland									
24a. REC'D BY REGISTRAR DATE Mar 5 '58									
24b. REGISTRAR'S SIGNATURE R. A. Pumphrey									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

GOULDING V. S.

100-310

100-310

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2158

CERTIFICATE OF DEATH

Reg. Dist. No.

02119

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 8 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,402 GEORGIA AVENUE				d. STREET ADDRESS 10,402 GEORGIA AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DENA		First T.	Middle DELLENOCHI	Last DELLENOCHI	4. DATE OF DEATH FEB. 18 1958	Month FEB.	Day 18	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/15/91	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JACK PASSIATORE				14. MOTHER'S MAIDEN NAME CONSTANCE PERRANI					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Anthony N. Dellenoci, 10,402 Ga. Ave.		Address Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastases to abdomen + liver about 1 year 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO of ovary - (c)						INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stab wound							
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1835 Eye St. N.W., Wash. D.C.	20f. (City or town) Montgomery County	(County) Montgomery	(State) MD				
21. I certify that I attended the deceased from July 1, 1957 to Feb. 18, 1958 , that I last saw the deceased alive on Feb. 8, 1958 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 Eye St. N.W., Wash. D.C. DATE SIGNED Feb. 18, 1958									
ACTUAL SIGNATURE Donald H. Lepper, Jr.		PHYSICIAN'S NAME (Type) DONALD H. LEPPER, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/21/58	22c. NAME OF CEMETERY OR CREMATORIUM GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND						
23. FUNERAL DIRECTOR'S SIGNATURE Werner S. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE FEB 24 1958	24b. REGISTRAR'S SIGNATURE W. S. HUMPHREY					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be relied upon by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

113 - 5 - 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2159

CERTIFICATE OF DEATH

02120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Damascus				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Sharon Nursing Home"				d. STREET ADDRESS R.F.D. Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary A. Denny		First	Middle	Last	4. DATE OF DEATH Feb. 1	Month	Day	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1875	9. AGE (in years last birthday) 82	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stenographer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Denny				14. MOTHER'S MAIDEN NAME Mary Hammond				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -		16. SOCIAL SECURITY NO - - -		17. INFORMANT Mrs Gertrude Drake, Mt. Airy, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4x80.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>Water ischemic cardio vascular disease</i> <i>10 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Damascus, Md.		(County) Towson, Md. (State) Md.
21. I certify that I attended the deceased from <i>Nov. 10, 1955</i> , to <i>Feb. 1, 1958</i> , that I last saw the deceased alive on <i>January 30, 1958</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James P. Kerr</i>						ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED
PHYSICIAN'S NAME (Type) James P. Kerr						Damascus, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill		22d. LOCATION (City, town, or county) Towson, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Molson</i>		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR FEB 6 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		

PURAV V. L

FEB. 6 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2160

CERTIFICATE OF DEATH

Reg. Dist. No.

02121

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. STREET ADDRESS <u>5 Charles Street</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Joseph</u>	Middle <u>Owen</u>	Last <u>Devlin</u>	4. DATE OF DEATH <u>February 25, 1958</u>	Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1910</u>	9. AGE (In years lost, birthday) <u>47 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laboratory Research</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Devlin</u>			14. MOTHER'S MAIDEN NAME <u>Mary B. Flannery</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-09-1292</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cirrhosis of the Liver, Laennec type (c)		6 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>February 11, 1958</u> , to <u>February 25, 1958</u> , that I last saw the deceased alive on <u>February 25, 1958</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2/26/58</u>							
ACTUAL SIGNATURE <u>Bernard Kliman</u>		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) <u>Bernard Kliman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Mar 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alv. Seach</u>	

SCHEAU V.

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2161

CERTIFICATE OF DEATH

Reg. Dist. No.

02122

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cinnery		c. LENGTH OF STAY IN 1b 1Da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg, Co. General Hosp,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (Rural)	
3. NAME OF DECEASED (Type or print) First Douglas Middle Byrnee Last Diamond		4. DATE OF DEATH Feb 17th Month Day Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1871-1890
			9. AGE (in years last birthday) 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Dairyer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Gaithersburg, Md
		12 CITIZEN OF WHAT COUNTRY) U.S.A.	
13. FATHER'S NAME John B. Diamond		14. MOTHER'S MAIDEN NAME Grace R. Ranney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Carroll M. Diamond. Gaithersburg, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60dx due to <i>Ventricular, due to</i> INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>Cerebral Pyelonephritis</i> 5 years			
DUE TO } (c) <i>St. ag. Storm Calculus</i> 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.p.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 16, 1957</i> to <i>Feb. 17, 1958</i> , that I last saw the deceased alive on <i>Jan. 16, 1958</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jack Schumacher, M.D.</i> ADDRESS (Street, city or town, state) <i>26 N. Summit Ave., Gaithersburg, Md.</i> DATE SIGNED <i>Feb. 19, 1958</i> PHYSICIAN'S NAME (Type) <i>Jack Schumacher</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-25-58	22c. NAME OF CEMETERY OR CREMATORIAL St Rose	22d. LOCATION (City, town or county, St. (State)) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Ernest C. Gartner. Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE <i>Feb. 24, 1958</i>	24b. REGISTRAR'S SIGNATURE <i>F. Ernest C. Gartner</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURLIN X

FEB 24 1962

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02123

2100 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park, Md.</i>		c. LENGTH OF STAY IN 1b <i>15 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>1430 Highland Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Joseph</i>	Last <i>Dolan</i>	DATE OF DEATH <i>Feb. 17</i>	Month <i>Feb</i>	Day <i>17</i>	Year <i>1958</i>	
4. SEX <i>Male</i>		5. COLOR OR RACE <i>White</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>8-6-88</i>	8. AGE (In years last birthday) <i>69 yrs.</i>	9. IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bank director</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John F Dolan</i>		14. MOTHER'S MAIDEN NAME <i>Rose Crawford</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>217-16-0085</i>		17. INFORMANT <i>chart-admission record</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>						INTERVAL BETWEEN ONSET AND DEATH <i>—</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Bronchogenic carcinoma (rt)</i>									
(c) DUE TO <i>Congestive heart failure</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D.</i>		20f. (City or town) <i>Princetown</i>		(County) <i>P.M.</i>	(State) <i>MD.</i>
21. I certify that I attended the deceased from <i>Jan. 12, 1957</i> to <i>Feb. 17, 1958</i> , that I last saw the deceased alive on <i>Feb. 17, 1958</i> , and that death occurred at <i>212 M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>J. Marion Beauford</i>		ADDRESS (Street, city or town, state) <i>9241 Col. Blvd</i>		DATE SIGNED <i>2/17/58</i>					
PHYSICIAN'S NAME (Type) <i>J. Marion Beauford</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT <i>2/21/58</i>		22b. DATE THEREOF <i>2/21/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN MAUSOLEUM</i>		22d. LOCATION (City, town, or county) <i>PRINCE GEO. COUNTY, MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Humphrey,</i>		ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Warren G. Humphrey</i>			

BUREAU X. E.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2162 CERTIFICATE OF DEATH

Reg. Dist. No.

02124

1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) En Route to Hospital see 1d			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Burtonsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Alberta	Middle —	Last Downs	4. DATE OF DEATH	Month February	Day 27	Year 19 58
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/03		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 		IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George Edwards			14. MOTHER'S MAIDEN NAME Ella Gray			Address 		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Harry Downs		Same 		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 420.1 Conditions, If any, which goes rise to immediate cause (a), stating the under- lying cause last. Coronary insufficiency, acute (b) Pulmonary Embolism DUE TO 30 minutes (c) 70 minutes								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sandy Spring	(County) Montgomery	(State) Md.
21. I certify that I attended the deceased from 27/2/61 , 1958, to 27/2/27 , 1958, that I last saw the deceased alive on 27/2/58 , 1958, and that death occurred at 12 PM , from the Causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland								
ACTUAL SIGNATURE J.W. Bird, M.D.								
DATE SIGNED 27/2/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 3, 1958		22b. DATE THEREOF March 3, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		22d. LOCATION (City, town, or county) Burtonsville, Montgomery, Md.		
(State) Md.								
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Wallace		ADDRESS 254 Carroll St.		24a. REC'D BY REGISTRAR DATE 		24b. REGISTRAR'S SIGNATURE Arthur Wallace		

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that no hospital or attending physician may be retained by the hospital or attending physician.

○ FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MAR 3 19

REGISTRATION
RECEIVED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US Rt. 29				d. STREET ADDRESS 2 Crain Highway										
3. NAME OF DECEASED (Type or print)		First Carlos	Middle Austin	Last Downs	4. DATE OF DEATH February	Month 4	Doy 19	Year 58						
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1915	9. AGE (In years last birthday) 42 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. FATHER'S NAME Richard D. Downs	14. MOTHER'S MAIDEN NAME Dora L. Murray	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-24-8030	17. INFORMANT Singleton Funeral Home, Glen Burnie, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15X Thoracic hemorrhage				INTERVAL BETWEEN ONSET AND DEATH sudden										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. crushed chest														
(b) DUE TO auto accident														
(c) DUE TO														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Fracture of right ankle														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Was passenger in car involved in auto accident.										
20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. 2/4/58 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. R. 29						
								(City or town) Burtonsville						
								(County) Montg.						
								(State) Md.						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED February 5, 1958.						
EXAMINER'S NAME (Type) Frank J. Broschart														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Nichols-Bethel Cemetery		22d. LOCATION (City, town, or county) Odenton, Maryland		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <i>Singleton</i>		ADDRESS		24. REC'D BY REGISTRAR VS A15ME		24. REGISTRAR'S SIGNATURE <i>W. F. Smith</i>								
VS A15ME 5M 2/57														

BUREAU V. S

FEB 10 19

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2164

CERTIFICATE OF DEATH

Reg. Dist. No.

02126

1 PLACE OF DEATH o COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	LENGTH OF STAY IN 1b hrs. <i>Suburban</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	d. COUNTY <i>Montgomery</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. STREET ADDRESS <i>2511 Mason Street</i>	
3 NAME OF DECEASED (Type or print) <i>Thomas Alan Duncan</i>		4. DATE OF DEATH <i>2 28 1958</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 2, 1935</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John M. Duncan</i>		14. MOTHER'S MÄDEN NAME <i>Sarah W. Bartlett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>+</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>John M. Duncan Father</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>340.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb. 28, 1958</i> , to <i>Feb. 28, 1958</i> , that I last saw the deceased alive on <i>Feb. 28, 1958</i> , and that death occurred at <i>4:48 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5402 Conn. Ave., N.W., Washington, D.C.</i>			
DATE SIGNED <i>Mar. 1, 1958</i>			
ACTUAL SIGNATURE <i>Harold M. Hobart</i>			
PHYSICIAN'S NAME (Type) <i>HAROLD M. HOBART</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>3/3/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>Mar 6 '58</i>
			24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>

BUREAU Y.

MAR 6 1948

U.S. GOVERNMENT

1
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
2126

Reg. Dist. No.

02121

FOR STATE

HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retain for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		b. COUNTY	
c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Philomena Nursing Home Rt 1 - Box 45-X		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH	
Charles Pele Earle		Feb 9, 1958	
5. SEX		Month Day Year	
Male White		12 23 1871	
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	
White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener		10b. KIND OF BUSINESS OR INDUSTRY Private	
11. BIRTHPLACE (State or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? N.S.C.	
13. FATHER'S NAME Daniel Earle		14. MOTHER'S MARRIED NAME Rachael Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT Nursing Home Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion	
420.1		INTERVAL BETWEEN ONSET AND DEATH sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 2-9-58	
ACTUAL SIGNATURE: <i>Frank J. Broshart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type): <i>Frank J. Broshart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) Sedat Hill Cem. Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE At. Don. Gelot, 2224 31st Ave. DC		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
		24b. REGISTRAR'S SIGNATURE Allie Finch	

DEAN V. S.

8035

CEALIN

102128

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AT SAME
SM 2/57

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived—If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 40 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7625 Maple Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
3. NAME OF DECEASED (Type or print) Frank V. Eastman		f. STREET ADDRESS 7625 Maple Ave			
3. NAME OF DECEASED (Type or print) Frank V. Eastman		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH OCT. 8, 1874	9. AGE (In years last birthday) 83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MINNEAPOLIS, MINN	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN B. EASTMAN		14. MOTHER'S MAIDEN NAME Alice Holler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 111-11-1111			
17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (INTERVAL BETWEEN QUEST AND DEATH) Found dead at home					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	EXAMINER'S NAME (Type) Frank J. Broschart		M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 2/20/58
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 25, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Royal Palms CEM	22d. LOCATION (City, town, or county) ST PETERSBURG, FLORIDA	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hector Hall</i>	ADDRESS 104-1112, DC	24a. REC'D BY REGISTRAR DATE FEB 25 '58	24b. REGISTRAR'S SIGNATURE Alv. French		

May V. 81

80



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2165

CERTIFICATE OF DEATH

02129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 333 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 4122 Emery Place, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First David	Middle Hobson	Last Edgin	4. DATE OF DEATH February 3, 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1899	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME George M. Edgin		14. MOTHER'S MAIDEN NAME Luella Mayfield		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 579-05-0329		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure				INTERVAL BETWEEN ONSET AND DEATH 5 days	
154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Pulmonary Metastases DUE TO				1 yr	
(c) Carcinoma of Rectum DUE TO				2 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Disease				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1958 , to February 3, 1958 , that I last saw the deceased alive on February 3, 1958 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland					
ACTUAL SIGNATURE Kurt W. Kohn		M.D.		DATE SIGNED 2/3/58	
PHYSICIAN'S NAME (Type) Kurt W. Kohn, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Tomb		22b. DATE THEREOF 2/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Nat. Mem. Park Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home		ADDRESS 5103 Wisconsin		24a. REC'D BY REGISTRAR DATE FEB 7 '58	
				24b. REGISTRAR'S SIGNATURE Alvin Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUENA V.

3 - 19

RECEIVED

X

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2166		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Montgomery		MARYLAND		a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Chevy Chase		5 mo		X Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2622 Blaue Dr		2622 Blaue Dr			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	DATE OF DEATH
Jeanne			Eisenberg	2 - 22	1958
4. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-11-1891	66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Russia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Morris Wolfson		Rachael Wolfson		Russia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or Unknown) Home		16. SOCIAL SECURITY NO		17. INFORMANT Address	
(If yes, give war or dates of service)				John H. Schneider - Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO		Acute Congestive heart failure		1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		by festination		10 yrs	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		FRANK J. BROSCHEIT		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type)		FRANK J. BROSCHEIT		DATE SIGNED 2-22-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		2/23-1958		Treas Israel Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Goldberg Funeral Home Washington DC				24b. REGISTRAR'S SIGNATURE William Peoples	
VS. A15ME SM 2/57				DATE 2/26/58	

WILHELM V.

1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. (12131)				
2167 CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland			b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville—Rural			c. LENGTH OF STAY IN 1b 13 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barnesville—Rural			d. STREET ADDRESS /					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS /			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ernest			First Elkins Middle Elkins Last			4. DATE OF DEATH Feb 17			Month	Day	Year			
5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Oct. 28-1876			9. AGE (In years lost birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farm owner			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Winchester-Kentucky			12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME James Elkins						14. MOTHER'S MAIDEN NAME Nancy C. Wills								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO None			17. INFORMANT Mrs Mary Dudley-Barnesville, Md. R.F.D			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1			DUE TO Bronchial Pneumonia, Recurrent						INTERVAL BETWEEN ONSET AND DEATH 39 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			DUE TO Arteriosclerotic Cardiovascular Disease						6 years					
(c)														
19. WAS A STOMPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 47x Multiple hemangiomas				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 6 Jan , 1958, to 17 Feb , 1958, that I last saw the deceased alive on 17 Feb , 1958, and that death occurred at 4 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Barnesville, Md.				
ACTUAL SIGNATURE Gordon M. Smith										DATE SIGNED 18 Feb 58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2/22/58			22c. NAME OF CEMETERY OR CREMATORIUM Winchester			22d. LOCATION (City, town, or county) (State) Winchester, Kentucky					
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hellas, Barnesville, Md.			ADDRESS			24a. REC'D. BY REGISTRAR DATE FEB 21 58			24b. REGISTRAR'S SIGNATURE W. B. Hellas					

SURNAME V. S

1893 65

NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2168

CERTIFICATE OF DEATH

02132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b		d. STATE Maryland	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		e. STREET ADDRESS 6810 Meadow Lane		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Angela Agnes ENGLER		First	Middle	Last	4. DATE OF DEATH February 10, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1891	9. AGE (In years last birthday) 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York City	
13. FATHER'S NAME Francisco Ginechesi		14. MOTHER'S MAIDEN NAME Theresa Ula			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Herbert A. Engler-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma - Plasma cell type DUE TO 203X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____					
INTERVAL BETWEEN ONSET AND DEATH 2 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY—Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ a. M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Stewart Clapp</i> ADDRESS (Street, city or town, state) M.D. 3921 Ingomar St. N. W. Wash. D. C. 2/11/1958 DATE SIGNED <i>2/11/58</i>					
PHYSICIAN'S NAME (Type) Stewart Clapp, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	
22d. LOCATION (City, town, or county) Washington		(State) Dist. Col.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 13 '58	
				24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>	

BUREAU V. S.

FEB 13 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2102 CERTIFICATE OF DEATH

Reg. Dist. No.

02133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3417 Fessenden St. N. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 Albany St. Oak Haven Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ADELINE KING EPPLEY		First	Middle	Last	4. DATE OF DEATH FEB	Month	Day	Year 22 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1871	9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas A. King		14. MOTHER'S MAIDEN NAME Alverty Carrick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lydia Speigler-3417 Fessenden St. NW		Address Washington, DC		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		DUE TO 331X		INTERVAL BETWEEN ONSET AND DEATH 10 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. None		(b) DUE TO CEREBRAL HEMMORHAGE		1 year				
(c) DUE TO ARTERIOSCLEROSIS				—				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEMIPLEGIA LEFT Total; SENILITY								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 249 Missouri Ave N.W.	(County) Washington	(State) D.C.
21. I certify that I attended the deceased from April 1, 1958 , to FEB 22, 1958 , that I last saw the deceased alive on FEB 21, 1958 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above.								
22. MEDICAL CERTIFICATION ACTION SIGNATURE S. A. Hillman		ADDRESS (Street, city or town, state) 249 Missouri Ave N.W. 2/22/58						
DATE SIGNED 2/22/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/58		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		ADDRESS		24a. REC'D. BY REGISTRAR FEB 24 1958		24b. REGISTRAR'S SIGNATURE John L. Hines		

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2169

CERTIFICATE OF DEATH

Reg. Dist. No.

112134

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	d. STREET ADDRESS <i>12926 Dean Rd</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Euphemia</i>	First _____	Middle _____	Last _____	4. DATE OF DEATH Month <i>Feb.</i> Day <i>26</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 28, 1894</i>	9. AGE (In years last birthday) <i>63 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>Antonio Trentacoste</i>	14. MOTHER'S MAIDEN NAME <i>Maria P. Farara</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no (or unchanged) <i>NC</i>	16. SOCIAL SECURITY NO. <i>364-36-7596</i>	17. INFORMANT <i>Daughter</i>	Address <i>12,926 Dean Road, Silver Spring, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic failure with jaundice</i> DUE TO <i>153.8</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Metastatic carcinoma</i> DUE TO <i>6 months</i> } (c) <i>Carcinoma of colon</i> DUE TO <i>6 months</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Sept 24</i> , 1958, to <i>February 26</i> , 1958, that I last saw the deceased alive on <i>February 25</i> , 1958, and that death occurred at <i>1:00 PM</i> , from the causes and on the date stated above					
ACTUAL SIGNATURE <i>Aaron H. Traum</i>	ADDRESS (Street, city or town, state) <i>M.D. 8237 Georgia Ave Silver Spring, Md. 20910</i> DATE SIGNED				
PHYSICIAN'S NAME (Type) <i>AARON H. TRAUM</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL</i>	22b. DATE THEREOF <i>3/1/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. OLIVET CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>SAGINAW, MICHIGAN</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Lumpkey</i>	ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>Feb 20 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Debra Smith</i>		

Y. G.
MELBA

CEB - 1093

150-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2175 CERTIFICATE OF DEATH

Reg. Dist. No.

02140

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Saints Spring Monty</i> , MARYLAND		a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Saint Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland</i>		d. STREET ADDRESS <i>R.F.D.#2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Frank Smith (Felder)</i>		4. DATE OF DEATH Month <i>2</i> Day <i>16</i> Year <i>1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/17/77</i> <i>XXXXXX XXXXX</i>
9. AGE (In years last birthday) <i>80 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>Days</i> Hours <i>Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Masonry contractor (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <i>Joseph Fields</i>		11. BIRTHPLACE (State or Foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. MOTHER'S MAIDEN NAME <i>Phoebe Schreve</i>		14. MOTHER'S MAIDEN NAME <i>Hazel Virginia Fields, R.F.D.#2</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-07-7111 A</i>	
17. INFORMANT <i>Hazel Virginia Fields, R.F.D.#2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myositis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/21/58</i> to <i>2/16/58</i> that I last saw the deceased alive on <i>2/14/58</i> , and that death occurred at <i>Saints Spring, MD</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J.W. Bird</i> PHYSICIAN'S NAME (Type) <i>JAMES J. W. BIRD</i>		ADDRESS (Street, city or town, state) <i>Saints Spring, MD</i> DATE SIGNED <i>2/18/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2/21/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>FT. LINCOLN CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren G. Lumpley</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>L. L. L. - L. L. L.</i>

BUREAU X. E.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2170 CERTIFICATE OF DEATH

Reg. Dist. No. 2135

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 4921 Georgia Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First George	Middle Justin	Last FIELD	4. DATE OF DEATH February 19	Month Day Year 19 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 16 August 1888	9. AGE (In years from b. birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bowling Alley Assistant		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Texas					
12. CITIZEN OF WHAT COUNTRY U.S.									
13. FATHER'S NAME Eldon FIELD		14. MOTHER'S MAIDEN NAME Margaret PEGGS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579 26 5967		17. INFORMANT (Wife) Mrs. Ethel Field (Same As #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease unknown INTERVAL BETWEEN ONSET AND DEATH 									
4.0.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 		DUE TO 							
{ 		{ 							
DUE TO 		DUE TO 							
(b) 		(c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 	(County) 	(State) 	
21. I certify that I attended the deceased from 16 January 1958 to 19 February 1958 , that I last saw the deceased alive on 19 February 1958 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 	DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 2-20-58		
ACTUAL SIGNATURE C. U. Shilling		PHYSICIAN'S NAME (Type) C. U. SHILLING LT MC USN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 1400 Chapin St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE W.W. Chambers			

RECEIVED

BUREAU V.

FEB 24 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2171 CERTIFICATE OF DEATH

02136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase		d. STREET ADDRESS 4823 Leland St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4823 Leland St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) L. Prescott		First	Middle	Last	4. DATE OF DEATH FEB. 1, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 18, 1902		9. AGE (In years last birthday) yrs 55	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 10 Days 13 Hours 0 Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cardiographic		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.		11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Geary A. Fisher		14. MOTHER'S MAIDEN NAME Mattie Connelly						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-30-2874		17. INFORMANT Wife Camille R. Fisher		Address Item #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO MYOCARDIAL INFARCTION Ruptured		INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO MYOCARDIAL INFARCTION WITH ANEURYSM		6 1/2 Years				
19. MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept , 19 51 , to Feb 1 , 19 58 , that I last saw the deceased alive on JAN 30 , 19 58 , and that death occurred at 6:50 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Washington 16 D.C.					DATE SIGNED 2-2-58	
ACTUAL SIGNATURE P.P. Andrews M.D.		PHYSICIAN'S NAME (Type) P.P. ANDREWS MD.						
22a. BURIAL, CREMATION, RELEASING (Specify) Burial		22b. DATE THEREOF 2/4/1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Rockville (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 5 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

KIEGELE

BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2172 CERTIFICATE OF DEATH

Reg. Dist. No. **02137**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 12004 Milton St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeBeau Gardens				d. STREET ADDRESS 12004 Milton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	SARAH First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
FRAZER	FRANTZ	G.	FRAZER	FEB 21			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>				Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? El. S.A.	
13. FATHER'S NAME Nason St. Gourley				14. MOTHER'S MAIDEN NAME Annie E. Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT None				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Heart Failure DUE TO (c) Anterior seborrheic, generalized			
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Feb. 20 1958							
21. I certify that I attended the deceased from Feb. 20, 1958 to Feb. 20, 1958 that I last saw the deceased alive on Feb. 20, 1958 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau				ADDRESS (Street, city or town, state) 10509 Concord St			
PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU				DATE SIGNED 2-21-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS 2901-14 St. NW		REC'D BY REGISTRAR Reg. Dist. No. 02137		24b. REGISTRAR'S SIGNATURE Reg. Dist. No. 02137	
		DATE FEB 24 1958					

RECEIVED
FEB 24 1959

BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112138

: 2173 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY IN lb <u>X Germantown</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <u>Bertie Beckwith</u>		First <u>Frazer</u>	Middle <u>Beckwith</u>			
4. DATE OF DEATH <u>February 22 1958</u>		Month <u>February</u>	Day <u>22</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 8, 1877</u>		9. AGE (In years last birthday) <u>80</u>	10. IF UNDER 1 YEAR Months <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>						
13. FATHER'S NAME <u>James Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Emily Talley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Address</u>				
17. INFORMANT <u>Joseph Frazer, Germantown, Md</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage.</u> DUE TO <u>443 X</u> Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 months</u> <u>10 years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Left hemiplegia.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>
21. I certify that I attended the deceased from <u>9 June</u> , 19 <u>48</u> , to <u>22 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Feb</u> , 19 <u>58</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Dawsonville</u> DATE SIGNED <u>John G. Fawcett</u> M.D. <u>John G. Fawcett</u>						
ACTUAL SIGNATURE <u>John G. Fawcett</u>		PHYSICIAN'S NAME (Type) <u>John G. Fawcett MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Asbury</u>	22d. LOCATION (City, town, or county) <u>Germantown, Md</u> (State) <u> </u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Int. inc.</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Poll 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SURÉAU V. S.

MAR 3 1959

LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 123-2-1-5 8th

CERTIFICATE OF DEATH

Reg. Dist. No. 02139

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nash D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>William Taylor Green</i>		d. STREET ADDRESS <i>6433-87th st N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>William Taylor Green</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX <i>M</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>3/22/75</i>
8. DATE OF DEATH <i>Feb 7 1958</i>	9. AGE (In years last birthday) <i>82 1/2 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Taylor Green</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Day</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Julian Day FREEMAN 6433-87-5112</i>	
17. INFORMANT <i>Julian Day FREEMAN 6433-87-5112</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>170X</i>			
(c) DUE TO <i>170X</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>dec 1946</i> to <i>Feb 7 1958</i> that I last saw the deceased alive on <i>Feb 7 1958</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>H. E. Kreuzburg</i>		DATE SIGNED <i>3/7/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2/10/58</i>		22b. DATE THEREOF <i>2/10/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cem</i>		22d. LOCATION (City, town, or county) <i>Wash D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Wash D.C.</i>		ADDRESS <i>300-4th st N.E.</i>	
24a. REC'D BY REGISTRAR <i>Feb 10 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

BUREAU V. A.

EB 10 1973

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2176 CERTIFICATE OF DEATH

12141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 807 S. BELGRADE ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SUSAN	Middle EILEEN	Last FROST	4. DATE OF DEATH Feb. 17 1958	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1956	9. AGE (In years last birthday) 1-11-20	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT L. FROST		14. MOTHER'S MAIDEN NAME RITA P. O'DONNELL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT ALBERT L. FROST, 807 S. Belgrade Rd., Silver Spr..		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure — suffocation DUE TO 500X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Tracheo-bronchitis, acute DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Feb. 1958 , to 17 Feb. 1958 , that I last saw the deceased alive on 17 Feb. 1958 , and that death occurred at 954 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Robert A. Bier</i>	M.D. 9028 Woodland Dr., Silver Spring, Md. 2/18/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/20/58		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wanner L. Lumpfrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 24 '58		24b. REGISTRAR'S SIGNATURE <i>C. W. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS 14
1SM 9/55

BUREAU Y. S.

53 OA 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2177 CERTIFICATE OF DEATH

112142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Teltheda</i>		c. LENGTH OF STAY IN 1b <i>11 hrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Travilah Rd.</i>		d. STREET ADDRESS <i>Potowmickie, Md.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Saint John Hosp.</i>									
3. NAME OF DECEASED (Type or print)	First <i>Gartner</i>	Middle <i>Albert L</i>	Last <i></i>	4. DATE OF DEATH Month <i>Dec</i> Day <i>10</i> Year <i>49</i>	Month <i></i>	Day <i></i>	Year <i></i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10/9/85</i>		9. AGE (In years lost birthday) yrs. <i>76</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Artist, Writer, Rev.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Game Reserve</i>		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Joseph Gartner</i>		14. MOTHER'S MAIDEN NAME <i>Martha Garland</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>112-56-0819</i>		17. INFORMANT <i>Mr. Marion Cooley (Friend)</i>		Address <i>Rockville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Cardiac failure</i>						INTERVAL BETWEEN ONSET AND DEATH			
{ (b) <i>emphysema</i> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Darnestown</i>		20f. (City or town) <i>Gaithersburg</i>		(County) <i>F.D.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>13 Dec 1956</i> to <i>10 Dec 1956</i> , that I last saw the deceased alive on <i>9 Dec 1956</i> , and that death occurred at <i>6th & M</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>2611 Summit Ave.</i>					
ACTUAL SIGNATURE <i>G. Rosenberger</i>				DATE SIGNED <i>10/14/1956</i>					
PHYSICIAN'S NAME (Type) <i>G. Rosenberger</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-13-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Hanover Park Darnestown</i>		22d. LOCATION (City, town, or county) <i>Gaithersburg</i>		(State) <i>F.D.</i>	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Ernest Gartner, Gaithersburg Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>FEB 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert Rosenberger</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1928

REVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02143

Reg. Dist. No.

POR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be given as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6804 Fairfax Rd.		e. STREET ADDRESS 6804 Fairfax Rd.	
f. IS IT IDENTIFIED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Allen George Gartner		First	Middle
4. DATE OF DEATH Feb. 21, 1958		Last	Month
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/3/1893		9. AGE (In years from birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
10c. BIRTHPLACE (State or foreign country) Tenn.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. Gartner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW yes		16. SOCIAL SECURITY NO. XXXXXXXXXX	
17. INFORMANT Police Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Infarction DUE TO (c) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute pancreatitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland (County) Maryland (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 2/21/58	
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		22b. DATE THEREOF 2/25/58	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Maryland (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 24 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	

BUREAU X E

3 M 1958

61303-VL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2179

CERTIFICATE OF DEATH

02144
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 133 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2406 19th Street N. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Samuel	Middle Robert	Last GATES	4. DATE OF DEATH	Month February	Day 3	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 November 1865	9. AGE (In years last birthday) 92 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Basil Leonard GATES				14. MOTHER'S MAIDEN NAME Anna R. GARNER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Spanish Am War		17. INFORMANT Address unknown		(Son) Robert Marshall GATES (Same as #2)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-2-5 DUE TO Infarction, myo cardium 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO ASHD unknown (c)								
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 		(State)
21. I certify that I attended the deceased from 23 September 1957 to 3 February 1958 , that I last saw the deceased alive on 3 February 1958 , and that death occurred at 9:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>C.U. Shilling</i> ADDRESS (Street, city or town, state) NAME (Type) C.U. SHILLING LT MC USA DATE SIGNED M.D. U.S. Naval Hospital, Bethesda Md. 2-4-58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) Annapolis (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE LEE Funeral Home 4th and Massachusetts Ave. N.E.		ADDRESS Washington, D.C.		24a. REC'D. BY REGISTRAR FEB 6 1958		24b. REGISTRAR'S SIGNATURE Lee		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

SEARCHED

INDEXED

FILED

DECEMBER 6 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2180

CERTIFICATE OF DEATH

112145.
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 617 Ponlar Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First George	Middle John	Last GERCKE	4. DATE OF DEATH February 29, 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 29 February 1904	9. AGE (In years from birth) 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motion Picture Producer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME George W. GERCKE		14. MOTHER'S MAIDEN NAME Minnette FRANCKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 133 16 8316		17. INFORMANT (Wife) Sarah A. GERCKE (Same as #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 16x		<i>29 Feb 1958</i> DUE TO Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		<i>Coronary of heart, post mortem state</i> DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 January 1958 to 8 February 1958 that I last saw the deceased alive on 8 February 1958 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. S. E. Green				ADDRESS (Street, city or town, state) M.D.U.S. Naval Hospital, Bethesda Md DATE SIGNED 2-9-58	
PHYSICIAN'S NAME (Type) W.E. GREER		LT MC USNR		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-11-58		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	
22d. LOCATION (City, town, or county) Suitland, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joe Steverson Sons</i>		ADDRESS 1756 Penn Ave. Wash. D.C.		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
				24b. REGISTRAR'S SIGNATURE / <i>Joe Steverson Sons</i>	

BUNNELL & CO

EE3

REGD TRADE

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

2131

CERTIFICATE OF DEATH

12146

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 67 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 910 - 10th Street, Apt. A-2						
3. NAME OF DECEASED (Type or print)	First Janet	Middle Leland	Last Gilmore					
4. DATE OF DEATH Month February	Day 10,	Year 19	58					
5. SEX White	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 14, 1952					
			9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS Days 26	Hours 5	Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Leland Gilmore			14. MOTHER'S MAIDEN NAME Celeste Funeri					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.2		Pseudomonas Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 Months		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Cystic Fibrosis of Pancreas				Since birth.		
DUE TO (c) Acute Cor pulmonale						7 days.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from December 5, 1957, to February 10, 1958, that I last saw the deceased alive on February 10, 1958, and that death occurred at 10:25 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Thomas F. Dolan Jr.</i>				M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		
PHYSICIAN'S NAME (Type)		DATE SIGNED						
THOMAS F. DOLAN, JR. M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1958		22c. NAME OF CEMETERY OR CREMATORIAL St. Rita's		22d. LOCATION (City, town, or county) Fayette County Pennsylvania (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS 24a. REC'D BY REGISTRAR FEB 13 '58 24b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>						

BUREAU V.

EEB 10 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2103

CERTIFICATE OF DEATH

12147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hospital</i>		d. STREET ADDRESS <i>8630 Piney Branch Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Wilmina</i>	Middle <i>Katherine</i>	Last <i>Coldsworth</i>	4. DATE OF DEATH 2	Month 1	Day 17	Year 1958
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-4-90</i>	9. AGE (In years last birthday) <i>67</i> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife & Proof Reader</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Printing Plant</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fred J. Uinger</i>		14. MOTHER'S MAIDEN NAME <i>Ella Montgomery</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>181-16-9128</i>		17. INFORMANT <i>Old Records - Husband</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis & embolism both renal & webs plus</i>		DUE TO <i>Thrombosis & embolism both renal & webs plus</i>		DUE TO <i>Hyperthyroid CVR disease</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>None</i>		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of the breast - metastases</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to _____, 1958, that I last saw the deceased alive on _____, 1958, and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.W. Danisit</i>		M.D.		ADDRESS (Street, city or town, state) <i>927 Beulah Rd Silver Spring, Md</i>		DATE SIGNED <i>2-17-58</i>	
22a. BURIAL, CREMATION, REMOVAL SPECIFY TRANS. & BURIAL 2/22/58		22b. DATE THEREOF <i>2/22/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Allegheny Co. Mem. Pk. Cemetery, Near Mt. Royal, Pa.</i>		22d. LOCATION (City, town, or county) (State) <i>Silver Spring, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Kimball</i>		ADDRESS <i>543 Main St.</i>		24a. REC'D BY REGISTRAR <i>12-24-58</i>		24b. REGISTRAR'S SIGNATURE <i>R. L. French</i>	

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FEB 04 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02148

2182 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		1816 ST. MARYLAND, FID BETHESEA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE MD.		b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL, and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1816 ST. MARYLAND, FID				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First, <i>Thomas</i>	Middle <i>Graham</i>	Last <i>Graham</i>	4. DATE OF DEATH	Month <i>FEB</i>	Day <i>16</i>	Year <i>1958</i>	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Housewife</i>		<i>HOME</i>		<i>FREDERICK MD</i>		<i>USA</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
<i>John Thomas</i>				<i>Sarah Abbott</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address <i>BETHESDA MD</i>			
(If yes, give war or dates of service)				<i>George J. Graham</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial failure, acute</i> One hour							
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first.									
{ (b) DUE TO		<i>Advanced coronary sclerosis</i> 10 yrs							
{ (c) DUE TO		<i>Hypertension and general arteriosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ 19 p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) _____	(State) _____
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3921 T. Ingman St. NW Wash. DC</i>							DATE SIGNED <i>2/16/58</i>
ACTUAL SIGNATURE <i>Stewart Clapp</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>2/20/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>AT. CLEVET</i>		22d. LOCATION (City, town, or county) <i>FREDERICK MD</i>		(State) <i>MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph F. Buckley</i>		ADDRESS <i>WASH. D.C.</i>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
				DATE <i>FEB 19 '58</i>					

BRUNAU Y. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112149

2183 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>513 Philadelphia Ave</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION <i>Takoma Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>ANNIE</i>	Middle <i>MAUDE</i>	Last <i>GRIFFIN</i>	4. DATE OF DEATH <i>Feb 2 1958</i>	Month <i>Feb</i>	Day <i>2</i>	Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 15, 1864</i>		9. AGE (In years last birthday) <i>93 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bird House</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Holyay, Love Scote</i>		12. CITIZEN OF WHAT COUNTRY <i>A.S.A</i>		
13. FATHER'S NAME <i>Not available</i>				14. MOTHER'S MAIDEN NAME <i>Not available</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT <i>Mr. Ezra C. Friend, 513 Philadelphia Ave T.P.M.D.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Renal. Vascular Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senile Atherosclerosis, Nervously d</i> DUE TO (c) <i>10- year</i> INTERVAL BETWEEN ONSET AND DEATH <i>9 mo.</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day <i>1</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7112 W. Elton Ave</i>	20f. (City or town) <i>Takoma Park</i>	(County) <i>Maryland</i>	(State) <i>Maryland</i>	
21. I certify that I attended the deceased from <i>Sept 1 1957</i> to <i>2 Feb 1958</i> , that I last saw the deceased alive on <i>31 Jan 1958</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H.B. Queen</i> ADDRESS (Street, city or town, state) <i>7112 W. Elton Ave Takoma Park MD</i> DATE SIGNED <i>2 Feb 1958</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 5, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) <i>Sloughton, Md.</i>		(State) <i>Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Winters, 254 Carroll St NW</i>				ADDRESS <i>254 Carroll St NW</i>		24a. REC'D BY REGISTRAR <i>15</i>	24b. REGISTRAR'S SIGNATURE <i>John Arthur Winters</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNEAU Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02150

2104 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)				
Montgomery MARYLAND		a. STATE	maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Takoma Park	6 days.	Silver Spring				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS					
Washington Sanitarium + Hospital	6 East Franklin Ave					
3. NAME OF DECEASED (Type or print)	First	Middle	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Katie		Elizabeth	Last Month Day Year			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-74	9. AGE (In years lost birthday) 84 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
female	white			84 yrs		
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Housewife				Baltimore MD		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
ISAAC Tyler		Mary BEDSWORTH Wilson		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
(If yes, give war or dates of service)				William Gross		6 E FRANKLIN AVE SILVER SPRING MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH
420.0		DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Thrombosis Left Coronary Artery		
{		DUE TO		Arteriosclerotic Heart Disease		
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 1958, to 19 FEB 1958, that I last saw the deceased alive on 18 FEB 1958, and that death occurred at 10:35 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE L.B. Snow		M.D.		9013 FLOWER AVE.		SILVER SPRING, MARYLAND
PHYSICIAN'S NAME (Type)						
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-58		22c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill		22d. LOCATION (City, town, or county) Washington, DC (State)
23. FUNERAL DIRECTOR'S SIGNATURE Neal Greenleaf Home 4812 Ge. Ave.		ADDRESS		24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE W. W. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 24 1958

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02151

2184 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 26 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1305 You Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edgar HAMILTON		First Middle Last	4. DATE OF DEATH February 13 1958	Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 June 1888	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administration, C & P Telephone Company		10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone Company		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME Edward HAMILTON		14. MOTHER'S MAIDEN NAME Sarah GUINN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Evelyn M. Hamilton (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 January 1958 to 13 February 1958 that I last saw the deceased alive on 12 February 1958, and that death occurred at 7:15A.M. from the causes and on the date stated above ACTUAL SIGNATURE Robert G. Muth ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-13-58					
PHYSICIAN'S NAME (Type) Robert G. Muth, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Private		22b. DATE THEREOF 2-17-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State)				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS Washington, D.C. Simmons Funeral Home, 1661 Goodhope Rd., S.E.		24a. REC'D BY REGISTRAR B 14 '58	
				24b. REGISTRAR'S SIGNATURE A. Leach	

BUNAU V. G.

FEB 14 1958

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2185 CERTIFICATE OF DEATH

(12152
215)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE District of Columbia		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2727 Jasper St., S.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Sharon		First	Middle Kay	Last HAMMER	4. DATE OF DEATH February 7	Month February	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 6 April 1957	9. AGE (In years last birthday) yrs 10	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Robert W. HAMMER		14. MOTHER'S MAIDEN NAME Kay M. VANROEKEL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT (Father) Robert W. Hammer (Same As #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.1		DUE TO Hypertension				INTERVAL BETWEEN ONSET AND DEATH 6 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Gastroenteritis				2 weeks		
(c)		Stephelycoid enterocolitis				2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1 February, 1958, to 7 February, 1958, that I last saw the deceased alive on 7 February, 1958, and that death occurred at 5:35A.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>Kenneth W. Sell</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 2-7-58						
PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 517 11th Street SE Washington D.C.		24a. REC'D BY REGISTRAR FEB 11 '58		24b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

ELIJAH V. S.

12



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2186 CERTIFICATE OF DEATH

112153

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md.		c. LENGTH OF STAY IN 1b RURAL and give nearest town Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS 3400 Bexhill Place	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HELEN	Middle LONON	Last HARRISON
4. DATE OF DEATH	Month Feb.	Day 15,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/1901
9. AGE (In years last birthday) 56	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days 20 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Huggins-Harrison	
11. BIRTHPLACE (State or foreign country) Marion, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David N. Lonon		14. MOTHER'S MAIDEN NAME Hester Yancey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-30-3773	
17. INFORMANT Blake B. Harrison, Jr. - Son		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of abdomen DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Metastatic carcinoma DUE TO			
(c) Origin undetermined			
INTERVAL BETWEEN ONSET AND DEATH 8 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , to Feb 16, 1958 , that I last saw the deceased alive on Feb 15, 1958 , and that death occurred at 1255A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 3921 Ingomar St NW, 216-58			
DATE SIGNED 2/16/58			
ACTUAL SIGNATURE Stewart Clapp			
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/58	
22c. NAME OF CEMETERY OR CREMATORIUM Oaklawn		22d. LOCATION (City, town, or county) (State) Marion, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE FEB 20 '58		24b. REGISTRAR'S SIGNATURE G. L. Johnson	

BUREAU V. S

FEB

RECEIVED

02154

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland	
2187		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coney		c. LENGTH OF STAY IN 1b 5 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co., Gen. Hosp.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First William Harrison		f. STREET ADDRESS Lincoln Park	
Middle		g. DATE OF DEATH Feb. 24, 1958	
Last		Month Day Year Feb. 24, 1958	
h. SEX male		i. COLOR OR RACE col.	
j. MARRIED <input type="checkbox"/>		k. NEVER MARRIED <input checked="" type="checkbox"/>	
l. WIDOWED <input type="checkbox"/>		m. DIVORCED <input type="checkbox"/>	
n. DATE OF BIRTH 2/23/1908		o. AGE (in years, months, days) 50 yrs	
p. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		q. KIND OF BUSINESS OR INDUSTRY	
r. FATHER'S NAME Unknown		s. BIRTHPLACE (State or foreign country) Fla.	
t. MOTHER'S MAIDEN NAME Unknown		u. CITIZEN OF WHAT COUNTRY? USA	
v. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		w. SOCIAL SECURITY NO.	
x. INFORMANT Police Record		y. Address	
z. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		AA. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock			
401X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage			
(c) Shot Gun wound in left groin		6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		BB. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
Fracture of left pelvis. Severance of bowel			
CC. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		DD. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
3:00 p.m. 2/24 1958		Reported shot while forceing entrance in accused home	
EE. TIME OF INJURY Month, Day, Year Hour		FF. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
GG. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HH. (City or town) (County) (State) nr Norbeck Montg. Md.	
II. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		JJ. DATE SIGNED 2/24/58	
KK. ACTUAL SIGNATURE Frank J. Roschart		MM. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
LL. EXAMINER'S NAME (Type) Frank J. Roschart		MM. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
NN. BURIAL CREMATION REMOVAL (Specify) Burial		OO. DATE THEREOF Lincoln Park, Md.	
PP. DATE THEREOF 2/28/58		QQ. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rockville, Md.	
RR. LOCATION (City, town, or county) Rockville, Md.		SS. DATE 2/24/58	
TT. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snodderly		UU. REC'D BY REGISTRAR MAR 3 '58	
VV. ADDRESS Rockville, Md.		WW. REGISTRAR'S SIGNATURE	

CHATEAU Y. S.

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CHATEAU Y. S.

02155

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

2188

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trousser permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Gaithersburg - R-2 life		Gaithersburg - R-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Etchison		Etchison	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Thomas Franklin Hawkins		Hawkins	
4. DATE OF DEATH		Month	Day
Feb. 9		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 4-5-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
merchant		Retail Groceries Md.	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Jos. C. Hawkins		General Store	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
4-20-1		217-32-680 Ernest Hawkins - Gaith. Md. R-2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Coronary occlusion		sudden	
DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify)		22b. NAME OF CEMETERY OR CREMATORIUM	
Burial Feb. II 1958		Mt. Tabor	
22d. LOCATION (City, town, or county)		(State)	
		Etchison	
Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR, DATE	
Roy W. Barber		FEB 7 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Laytonsville, Md.		SEARCH	
DATE			

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2105 CERTIFICATE OF DEATH

Reg. Dist. No.

02156

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE			
<i>Montgomery</i>				<i>Maryland</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Akoma Park</i>		<i>14 days</i>		<i>Bethesda</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS		e. IS RESIDENCE ON A FARM?					
<i>Washington San + Hosp.</i>		<i>2507 Henderson Ave.</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
<i>Martha Manzella Highman</i>					<i>2</i>	<i>4</i>	<i>4</i>	<i>1958</i>	
5. SEX		6 COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Female</i>		<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>9-22-94</i>	<i>63</i> yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Housewife</i>				<i>Maryland</i>		<i>U. S. A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
<i>Abner B. B. Bingham</i>		<i>Annie Robesson</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<i>No</i>		<i>718-18-001</i>		<i>Washington San + Hosp. Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma of Uterus w/Metastases</i>				<i>1 yr</i>			
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		(b)							
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED?			
<i>Thromboses of Vena Cava and Lungs</i>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m p. m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
<i>Jan 19 1958</i>		<i>19</i>							
21. I certify that I attended the deceased from <i>Jan 19 1958</i> , to <i>Feb 7 1958</i> , that I last saw the deceased alive on <i>Feb 4 1958</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE		<i>J. M. Witlock</i>				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)		<i>J. M. Witlock</i>				<i>2201 Carroll Ave 2-4-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
<i>Burial</i>		<i>2/7/58</i>		<i>Burkittsville Cem</i>		<i>Burkittsville</i>		<i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<i>Robert A. Pumphrey</i>		<i>Bethesda, Md.</i>		<i>FEB 6 '58</i>		<i>Officer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILHELM V. S.

1959

WILHELM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 F-1-1225 3-20-57 at

2189

CERTIFICATE OF DEATH

(12157)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sakurka's</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Kensington</i>	
3. NAME OF DECEASED (Type or print) <i>Dionysius</i>		d. STREET ADDRESS <i>Maple View Drive</i>	
First <i>H.</i>		Middle <i>I.</i>	Last <i>Hilton</i>
4. DATE OF DEATH Month <i>2</i> Day <i>- 20</i> Year <i>1958.</i>		5. SEX <i>Male</i>	
6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-28-1862</i>		9. AGE (In years last birthday) yrs. <i>95 1/4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>321-00-1234</i>	
17. INFORMANT <i>William T. Goff - Grandson</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>200-210 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>(b) Cerebral arteriosclerosis thrombosis?</i>			
DUE TO <i>(c) Left internal carotid artery</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <i>Septal myocardial infarction</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>inhalation pneumonia</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Feb. 19 1958</i>		20d. INJURY OCCURRED While Nat while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>104 Chevy Chase Dr.</i>		20f. (City or town) <i>Montgomery</i>	
(County) <i>MD</i>		(State) <i>MD</i>	
21. I certify that I attended the deceased from <i>Feb. 11, 1958</i> to <i>Feb. 20, 1958</i> that I last saw the deceased alive on <i>Feb. 20, 1958</i> , and that death occurred at <i>93 Chevy Chase Dr.</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Chevy Chase 15, Md.</i>		DATE SIGNED <i>2/21/58</i>	
ACTUAL SIGNATURE <i>George A. Gray Jr.</i>		PHYSICIAN'S NAME (Type) <i>George A. Gray Jr.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 24, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Damascus Meth.</i>		22d. LOCATION (City, town or county) <i>Damascus, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roy W. Barker Taylorville</i>		24a. RECEIVED BY REGISTRAR <i>FEB 26 '58</i>	
ADDRESS <i>114</i>		24b. REGISTRAR'S SIGNATURE <i>W. McLean</i>	

HOSPITAL OR INTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2190 CERTIFICATE OF DEATH

02158

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3622 Milford Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Floyd	Middle Garfield	Last Hoback	4. DATE OF DEATH February	Month 18	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1882	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Hoback			14. MOTHER'S MAIDEN NAME Alice Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL ADRENAL HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> 214X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>VASCULAR OCCLUSION, SMALL + LARGE BOWEL; MALIGNANT CARCINOID</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OF SMALL BOWEL					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
19							
21. I certify that I attended the deceased from February 6, 1958, to February 18, 1958, that I last saw the deceased alive on February 18, 1958, and that death occurred at 6:13 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Samuel Charache</u> M.D. Feb 19 1958 PHYSICIAN'S NAME (Type) Samuel Charache, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/1958	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery	22d. LOCATION (City, town, or county) Baltimore	(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600 Liberty Hghts. Ave.	ADDRESS	24a. REC'D BY REGISTRAR DATE 324 '58	24b. REGISTRAR'S SIGNATURE Signature				

BUREAU Y.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2191 CERTIFICATE OF DEATH

02159

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2325 15th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Harold		First Harold	Middle H E H	Lost HOLSBERRY	4. DATE OF DEATH February 2 1958	Month February	Day 2	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 April 1899		9. AGE (in years last birthday) 58 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0		Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Inspector		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.				
13. FATHER'S NAME Euphritis HOLSBERRY		14. MOTHER'S MAIDEN NAME Ruhala STUMP								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-I		17. INFORMANT (Wife) Mrs. Frances W. HOLSBERRY		Address (Same As #2)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction Myocardialis about 2 hours</i>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from 31 January, 1958 , to 2 February, 1958 , that I last saw the deceased alive on 1 February, 1958 , and that death occurred at 7:20A.M. from the causes and on the date stated above				ADDRESS (Street, city or town, state)		DATE SIGNED				
ACTUAL SIGNATURE <i>T.S. Dunn, Jr.</i>		M.D. U.S. Naval Hospital, Bethesda, Md. 2-3-58								
PHYSICIAN'S NAME (Type) T.S. DUNN, JR., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F Cemetery		22d. LOCATION (City, town, or county) Elkins, West Virginia		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Murphy</i>		ADDRESS R. A. Murphy, 1257 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE FEB 6 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>				

LIBRARY USE

FEB 6 1968

REF GELV E 0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02160

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN lb <i>7 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4407 Everett St</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
3. NAME OF DECEASED (Type or print) <i>Blair Ernest Hott</i>		f. STREET ADDRESS <i>4407 Everett St</i>	
3. NAME OF DECEASED (Type or print) <i>Blair Ernest Hott</i>		First <i>Blair</i>	Middle <i>Ernest</i>
3. NAME OF DECEASED (Type or print) <i>Blair Ernest Hott</i>		Last <i>Hott</i>	4. DATE OF DEATH <i>Feb 21 1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept 16 - '18</i>		9. AGE (in years last birthday) <i>39 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>store</i>	
10c. BIRTHPLACE (State or foreign country) <i>N.J.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ernest Hott</i>		14. MOTHER'S MAIDEN NAME <i>Bush</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no, or unknown If yes, give war or dates of service) <i>New York WWII</i>		16. SOCIAL SECURITY NO <i>123-45-6789</i>	
17. INFORMANT <i>Unknown</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
20a. TIME OF INJURY Hour e. m. p. m. <i>19</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>2-22-58</i>
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Augusta, W. Va.</i>
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Bur-Transit</i>	22b. DATE THEREOF <i>2/25/57</i>		24a. REC'D BY REGISTRAR <i>APR 4 '58</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey Bethesda, Maryland</i>	24b. REGISTRAR'S SIGNATURE <i>APR 4 '58</i>		

RECEIVED
BUREAU V. E.

EEB Pa 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2193

CERTIFICATE OF DEATH

Reg. Dist. No.

02161

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b RURAL and give nearest town WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 457 Washington	
f. STREET ADDRESS 2500 Q St., N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA		First G.	Middle Hughes
4. DATE OF DEATH Feb. 8 1958		Month Feb.	Day 8
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JULY 7, 1900		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	10c. BIRTHPLACE (State or foreign country) Hoosick Falls, N.Y.
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. ADDRESS Patricia Hughes-- Room 315 Senate	
13. FATHER'S NAME PATRICK Gannon		14. MOTHER'S MAIDEN NAME Mary Sherin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. XXXXXX	
17. INFORMANT Patricia Hughes		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 DUE TO Terminal Pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Hemiplegia -+ Invalidism 3 mos.	
DUE TO (c)		Glioma - Grade IV - Frontal lobe 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1958 , to Feb 8 1958 , that I last saw the deceased alive on Jan 15 1958 , and that death occurred at 5:17 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2023 - R St. N.W. Feb 8, 1958	
ACTUAL SIGNATURE Bernard E. Niney		DATE SIGNED 2/8/58	
PHYSICIAN'S NAME (Type) BERNARD E. NINEY MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 2/13/58		22b. DATE THEREOF 2/13/58	
22c. NAME OF CEMETERY OR CREMATORIUM ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) HOOSICK FALLS, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey Silver Spring		24a. ADDRESS Mc	
		24b. REC'D BY REGISTRAR DATE FEB 11 '58	
		24c. REGISTRAR'S SIGNATURE Webb	

RENEAU V. S.

FEB 11 1970

RENEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02162

2106 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY	
Takoma Park		5 days		District of Columbia		41/2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. DATE OF DEATH		g. IS RESIDENCE ON A FARM?	
Washington San. & Hospital		23 Regis Road, N.W.		February 14		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	Month	Day	Year
Sarah Anna Hyatt					February	14	1958
4. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH	
Female		White				9. AGE (In years lost birthday)	
				7/24/74		63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Russia		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Philip Hart		Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No				Daughter - Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
Cerebral Occlusion							
4/20.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Essential Hypertension							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from		Feb 9, 1958		to Feb 14, 1958		that I last saw the deceased alive on Feb 14, 1958, and that death occurred at 5:55 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)					
ARTHUR S. BRESCER M.D.		533 Regis Rd. N.W.					
PHYSICIAN'S NAME (Type)		Washington D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		FEB 17, 1958		TALMUD TORAH CEMETERY		CONGRESS HTS. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
B. Danzansky & Sons - 3501-14th St NW - Washington D.C.				FEB 19 '58		G. Leinrich	

BUREAU V. 2

FEB 4 1969

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02163

2194

CERTIFICATE OF DEATH

Item 3, Film G-229 5/21/58, sec.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Wash. D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4412 Greenwich Pkwy. N.W. 47x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle T. <i>77</i> Last Jaycox		4. DATE OF DEATH 10/25 Month, Feb. Day 23 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-76	
9. AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) New York, (East Fishkill) U.S.A.		12. CITIZEN OF WHAT COUNTRY? New York, (East Fishkill) U.S.A.	
13. FATHER'S NAME Warren Horton				14. MOTHER'S MAIDEN NAME Mar. ret Tilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Son <i>John C. Jaycox</i>		Address XXXXX XXXXXXX Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>bronchopneumonia, bilateral</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i> DUE TO <i>thrombophlebitis, rt. leg.</i> <i>(c)</i> DUE TO <i>cerebral vascular accident</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>471X</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>23 Feb</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>22 Feb</i> , 19 <i>58</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John M. Wyman</i> PHYSICIAN'S NAME (Type) <i>John M. Wyman</i> M.D. <i>7659 Georgetown Road</i> <i>23 Feb 58</i> ADDRESS (Street, city or town, state) <i>Bethesda 14, Maryland</i> DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/23/58		22c. NAME OF CEMETERY OR CREMATORIUM Mayflower		22d. LOCATION (City, town, or county) Duxbury, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR FEB 26 58		24b. REGISTRAR'S SIGNATURE <i>John M. Wyman</i>	

1938

1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112164

2195 CERTIFICATE OF DEATH

Item 14. File #220 2-2-51 pt

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE		Md b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Silver Spring				Silver Spring		109 Hilltop Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		109 Hilltop Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First EBER	Middle W.	Last JEFFERY	4. DATE OF DEATH	Month FEB.	Day 7	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS Days 0	Hours 0 Min 0
				12/13/1895	62 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired, Supervisory		D.C. Govt. Dir. History, DC		Michigan		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Jerod W. Jeffery		Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO		17. INFORMANT		Address Maurine A. Jeffery 109 Hilltop Rd., S.S. Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH ONE HOUR	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO		CARDIAC FAILURE						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		CARDIOVASCULAR-RENAL DISEASE SEV. YRS.						
(b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 1, 1958, to Feb. 7, 1958, that I last saw the deceased alive on Feb 7, 1958, and that death occurred at 7:30 P.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Lynwood Heights, M.D. 6940 Piney Branch Rd., N.W. 2/7/58					DATE SIGNED 2/7/58	
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type)								
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF 2/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Woodland Cemetery		22d. LOCATION (City, town or county) Quincy, Ill. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Wash, D.C.		24a. REC'D BY REGISTRAR Date 2/13/58		24b. REGISTRAR'S SIGNATURE		
The S.H. Hines Co., 2901 14th St. N.W.,								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after both.

BUREAU Y.

LB 11 1958

U.S. GOVERNMENT
PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2196 CERTIFICATE OF DEATH										02165						
										Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3610 Underwood Street					d. STREET ADDRESS 3610 Underwood Street					e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Jean		Middle Goulding		Last JEWELL		4. DATE OF DEATH Month February		Day 4		Year 19 58				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1893		9. AGE (in years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR 9 Months		11. IF UNDER 24 HRS 22 Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home					11. BIRTHPLACE (State or foreign country) Wisconsin						
12. CITIZEN OF WHAT COUNTRY? USA																
13. FATHER'S NAME Fred MacNickle					14. MOTHER'S MAIDEN NAME Mary Baum											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Henry H. Jewell-Item# 2						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Paroxysmal Ventricular Tachycardia, 5 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 minutes						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute upper respiratory infection.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 4:30 PM, from the causes and on the date stated above.											
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3729 Morrison St., N.W. Washington, D.C.						
20f. (City or town) Rockville, Md.					(County) Montgomery Co.					(State) Md.						
21. I certify that I attended the deceased from Mar 27, 1958 to Feb 4, 1958 , that I last saw the deceased alive on Feb 1, 1958 , and that death occurred at 4:30 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 3729 Morrison St., N.W. Washington, D.C.						
DATE SIGNED February 4, 1958																
ACTUAL SIGNATURE Thomas A. Wildman					M.D.											
PHYSICIAN'S NAME (Type) Thomas A. Wildman																
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/58			22c. NAME OF CEMETERY OR CREMATORIAL Parklawn			22d. LOCATION (City, town, or county) Rockville, Md.			(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.					ADDRESS					24a. REC'D BY REGISTRAR REG STRAHLER			24b. REC'D BY SIGNATURE REG STRAHLER			
										DATE Feb 6 '58						

BUREAU V. S.

FEB 6 1953

MCGRAW-HILL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2107 CERTIFICATE OF DEATH

Reg. Dist. No.

02166

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN b 16		d. STREET ADDRESS 65 Allison Street, NE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				4. DATE OF DEATH February 6, 1958		Month	Day	Year		
3. NAME OF DECEASED (Type or print)		First Johnson	Middle 	Last Johnson						
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH February 5, 1958		9. AGE (in years last birthday) yrs. 7	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours 	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 7				
13. FATHER'S NAME Thomas Eugene Johnson		14. MOTHER'S MAIDEN NAME Betty Jean Mannon								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Father		Address same address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 773.5		DUE TO Immaturity				INTERVAL BETWEEN ONSET AND DEATH 7 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO 				7 hrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5600 New Hampshire Ave., NE Washington, D.C.		20f. (City or town) 		(County) 	(State) 	
21. I certify that I attended the deceased from Feb. 5, 1958 , to Feb. 6, 1958 , that I last saw the deceased alive on Feb. 6, 1958 , and that death occurred at M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 				
ACTUAL SIGNATURE Samuel M. Bageant						DATE SIGNED 2-6-58				
PHYSICIAN'S NAME (Type) Samuel M. Bageant, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-10-58		22c. NAME OF CEMETERY OR CREMATORIUM Washington Sanitarium Hosp. Takoma Park Md		22d. LOCATION (City, town, or county) Takoma Park		(State) 		
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Hale, M. D. Wash. San. Hosp.		ADDRESS 		24a. REC'D BY REGISTRAR 2-11-58		24b. REGISTRAR'S SIGNATURE 				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

18-3-1928

BUREAU V. Bureau
18-3-1928

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2197

CERTIFICATE OF DEATH

02167

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 mos. 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3516 "B" Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Paul	Middle Francis	Last JOHNSON	4. DATE OF DEATH February 26	Month Day Year Day Year 1958
S SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 30 November 1908	9 AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min 0 Months 0 Days 0 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer, C&P Telephone Company		10b. KIND OF BUSINESS OR INDUSTRY Cable Splicer, C&P Telephone Company		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Allen Joseph JOHNSON		14. MOTHER'S MAIDEN NAME Florence THOMAS		12. CITIZEN OF WHAT COUNTRY U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT (Wife) Mrs. Mary Elsie JOHNSON (Same As #2)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Pneumonia (c) DUE TO Pericarditis Pericarditis Nodosa					
INTERVAL BETWEEN ONSET AND DEATH ca 2-3 days 6 days 9 mos -					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 October 1957 to 26 February 1958 that I last saw the deceased alive on 26 February 1958 , and that death occurred at 10:30 P.M. from the causes and on the date stated above					
ADDRESS (Street, city or town, state) M.D.U.S. Naval Hospital, Bethesda, Md.					
DATE SIGNED 2-27-58					
ACTUAL SIGNATURE <i>J. Dunn Jr.</i>					
PHYSICIAN'S NAME (Type) T. S. DUNN, JR., LT, MC, USN					
U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 March 1958		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Mattingly, 131 11th St., S.E. Washington, D.C.		ADDRESS G. A. Mattingly		24a. REC'D BY REGISTRAR FEB 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>Alfredus</i>	

BUREAU V. S.

EB 23 1958

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FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2198

CERTIFICATE OF DEATH

Reg. Dist. No.

02168

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 5134 Manning Drive		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5134 Manning Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Last	4. DATE OF DEATH February 1	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 21, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR 3 Months	IF UNDER 24 HRS. 10 Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Patterson, N. Jersey		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles O. Pelletreau		14. MOTHER'S MAIDEN NAME Elma A. House		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Miss Helen D. Jones-Same Item #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D.C.	(County) D.C.	(State) D.C.		
21. I certify that I attended the deceased from Jan. 33 , 1958, to Feb. 1 , 1958, that I last saw the deceased alive on Feb. 1 , 1958, and that death occurred at 11:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3937 Langdon Street, Washington, D.C. DATE SIGNED Sidney Cousins								
ACTUAL SIGNATURE SIDNEY COUSINS	PHYSICIAN'S NAME (Type) SIDNEY COUSINS	22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/4/58	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory	22d. LOCATION (City, town, or county) Prince Georges, Maryland	(State) MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.		ADDRESS 15M 9/55	24a. REC'D BY REGISTRAR 1/6/58	24b. REGISTRAR'S SIGNATURE R.A.P.				

BUREAU V. S

113 - 20

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2199 CERTIFICATE OF DEATH

02169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>at Rockville</i>		d. STREET ADDRESS <i>322 Remond Ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Baby</i>		First	Middle	Last	4. DATE OF DEATH <i>Boy Joppy</i>	Month <i>FEBRUARY</i>	Day <i>18</i>	Year <i>1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 18, 1958</i>	9. AGE (In years last birthday) yrs. <i>3</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS Days <i>10</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>JAMES VERNON HILL</i>		14. MOTHER'S MÄDEN NAME <i>Barbara Delores Joppy</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Arthritis</i> (c)		
						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs - 3 hrs</i>		
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20e. TIME OF INJURY Month, Day Year Hour o.m. p.m. 19		20f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20h. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>2/18/58</i> to <i>2/18/58</i> , that I last saw the deceased alive on <i>2/18/58</i> , and that death occurred at <i>11:28 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James M. Wilson</i> , M.D. ADDRESS (Street, city or town, state) <i>8218 Wisconsin Ave, Bethesda, Md.</i> DATE SIGNED <i>2/20/58</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		22b. DATE THEREOF <i>2-21-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Suburban Hospital</i>		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAR 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUREAU V. S.

MAR 3 19

100-250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2200

CERTIFICATE OF DEATH

02170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b SILVER SPRING 8 yrs.		b. COUNTY		MONTGOMERY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2514 LINDELL STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		f. STREET ADDRESS 2514 LINDELL STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMIE		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/47	9. AGE (In years lost birthday) 10 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES H. KEEBLER		14. MOTHER'S MAIDEN NAME ELSA G. HAYES						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. James H. Keebler, 2514 Lindell St.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X55X		DUE TO (b) Increased intra cranial pressure ?		Silver Spring, Md.		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {		DUE TO (c) Edema & enlargement of BRAIN						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) ADDRESS (Street, city or town, state)		(County) (State)
21. I certify that I attended the deceased from 6-22, 1947, to 2-19, 1958, that I last saw the deceased alive on 1-18, 1958, and that death occurred at 9:55 AM, from the causes and on the date stated above.						DATE SIGNED		
ACTUAL SIGNATURE CAROLYN S. PINCOK M.D.								
PHYSICIAN'S NAME (Type) CAROLYN S. PINCOK								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/21/58		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETRY		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Warner S. Humphrey,		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR FEB 24 1958		24b. REGISTRAR'S SIGNATURE		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V.

FEB 24 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2271

CERTIFICATE OF DEATH

02171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>		d. STREET ADDRESS <i>19207 Longbranch Rd</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9207 Longbranch Rd</i>				d. STREET ADDRESS <i>19207 Longbranch Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>AitheA</i>	Middle <i>D.</i>	Last <i>KEENE</i>	4. DATE OF DEATH <i>7-6-12</i>	Month <i>July</i>	Day <i>12</i>	Year <i>1958</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 1 1908</i>		9. AGE (In years less birthday) yrs. <i>49</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT.</i>		11. BIRTHPLACE (State or foreign country) <i>N CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>ADRIAN DODLEY</i>		14. MOTHER'S MAIDEN NAME <i>ADELAIDE HINES</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>378-20-6494</i>		17. INFORMANT <i>Husband SAM J.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>196.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO <i>(b) carcinoma of mandible with metastases</i>						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO <i>(c)</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month <i>January</i>	Day <i>19</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7120 P.M.</i>	20f. (City or town) <i>217 University Blvd E</i>	(County) <i>Seattle</i>	(State) <i>WA</i>
21. I certify that I attended the deceased from alive on <i>Feb. 12</i> , 19 <i>58</i> , and that death occurred at <i>7:20 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>217 University Blvd E</i>			
ACTUAL SIGNATURE <i>Bernard A Fitzgerald</i>		PHYSICIAN'S NAME (Type) <i>BERNARD A FITZGERALD</i>		M.D.		DATE SIGNED <i>2/12/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>FE 6.14 58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don McSol</i>		ADDRESS <i>2224 14th St NW</i>		24a. REC'D-BY REGISTRAR <i>FLW</i>		24b. REGISTRAR'S SIGNATURE <i>REC'D</i>			

July 28

Feb 18 1969

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

182172

2202 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Montgomery MARYLAND		Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville	c. LENGTH OF STAY IN 1b 35 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12910 Colesville Road	d. STREET ADDRESS 12910 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLELL	Middle H.	Last KELLER			
4. DATE OF DEATH	Month Feb.	Day 10	Year 1958			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 13, 1911	9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor	10b. KIND OF BUSINESS OR INDUSTRY Building Trades	11. BIRTHPLACE (State or foreign country) London County, Va	12. CITIZEN OF WHAT COUNTRY? U. S.A.			
13. FATHER'S NAME Albert M. Keller	14. MOTHER'S MAIDEN NAME Catherine Ecker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO 578-04-2545	17. INFORMANT Mrs. Edith B. Keller, (same as #2)	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 to 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial asthma				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colesville	(County)	(State)	
21. I certify that I attended the deceased from March 1950, to Feb 10, 1958, that I last saw the deceased alive on Feb 1, 1958, and that death occurred at 6:00 A.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE AARON H. TRAUM	M.D.	ADDRESS (Street, city or town, state) F237 Georgia Ave Silver Spring MD 20910				
PHYSICIAN'S NAME (Type) AARON H. TRAUM	DATE SIGNED 2/10/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 12, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Colesville Cemetery	22d. LOCATION (City, town, or county) Colesville			
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Waites, 254 Carroll St NW DC		ADDRESS 254 Carroll St NW DC	24a. REC'D BY REGISTRAR FEB 13 '58	24b. REGISTRAR'S SIGNATURE D. J. Nease		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2293

CERTIFICATE OF DEATH

Reg. Dist. No.

02173

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] b. STATE	
Montgomery Maryland		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda		Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Suburban		14521 Benson Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Thomas Francis Kelly		Liam	2
4. DATE OF DEATH		Month	Day
		2	2
		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	Nov. 27, 1879
8. DATE OF BIRTH		9. AGE (In years (age at birthday) yrs.)	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
		78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Foreman, Borders Milk Co., N.Y.C.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Martin Kelly		Brooklyn, N.Y. U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; if yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Daughter	
		Address	
		Mrs Roberta Smith	
		Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral Confluent Bronchopneumonia, Lung hemorrhage	
491X		3 hours	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), sloping the under- lying cause lost.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Arteriosclerotic - Heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1, 1958, to Feb. 2, 1958, that I last saw the deceased alive on Feb. 1, 1958, and that death occurred at 5:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		Heerman Magganzini M.D.	
PHYSICIAN'S NAME (Type)		Heerman Magganzini	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Feb. 5 '58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Mt. Olivet Cemetery		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Norman E. Humphrey		8454 Galore Rd.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
FEB 5 '58		Aut. death	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the certificate and given to the funeral director. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LAU V. 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02174		
2204 Items 1, 3, 15, 16, 18, 26, 3-3-58 et										Reg. Dist. No. 215.		
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN lb 16 days					b. COUNTY Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale							
3. NAME OF DECEASED (Type or print) George					First George	Middle William	Last KERN	4. DATE OF DEATH February 20 1958	Month February	Day 20	Year 1958	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 15 June 1921		9. AGE (In years last birthday) 36 yrs		IF UNDER 1 YEAR Months 36	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk					10b. KIND OF BUSINESS OR INDUSTRY Petraic Inc. Power Corp/Tele/Co. Co.					11. BIRTHPLACE (State or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? U.S.												
13. FATHER'S NAME George Henry KERN										14. MOTHER'S MAIDEN NAME Pauline Marie SCHORB		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW-II 579-12-6403		17. INFORMANT (Wife) Mrs. Margaret M. KERN (Same As #2)		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Bronchogenic Carcinoma										INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 4 February 1958 to 20 February 1958 , that I last saw the deceased alive on 20 February 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above										ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>James E. McClenathan</i>										DATE SIGNED 2-21-58		
PHYSICIAN'S NAME (Type) James E. McClenathan, CDR, MC, USN										M.D. U.S. Naval Hospital, Bethesda, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Natl. Cemetery			22d. LOCATION (City, town, or county) Arlington, Virginia			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		ADDRESS 4th & Mass. Ave., N.W. Wash.D.C.		24a. REC'D BY REGISTRAR FEB 24 1958			24b. REGISTRAR'S SIGNATURE <i>First</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

22:5

CERTIFICATE OF DEATH

Reg. Dist. No.

112175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		c. LENGTH OF STAY IN lb <u>2 yrs 5 mos 16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5517 Kennedy St. Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosemary Sanitarium & Hospital</u>		e. STREET ADDRESS <u>Kennedy Warren Apartments</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Maryaret</u>	Middle <u>Newton</u>	Last <u>Kerr</u>	4. DATE OF DEATH <u>February</u>	Month <u>4</u> Day <u>1958</u> Year
5. SEX <u>F. female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8 Dec 1867</u>	9. AGE (In years lost birthday) <u>90</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>Joseph H. Easter</u>		14. MOTHER'S MAIDEN NAME <u>Susan Blaney</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Leukemia Lymphatic</u> 3 years DUE TO (b) <u>Scenesence</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)			
20c. TIME OF INJURY Hour a. g. p. m.	Month 19	Day at work	20d. INJURY OCCURRED While Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1835 Eye St. N.W. Washington, D.C.</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-31-1958</u> to <u>2-4-1958</u> , that I last saw the deceased alive on <u>2-4-1958</u> , and that death occurred at <u>2-4-5PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Clapham P. King</u>		M.D.		DATE SIGNED <u>2-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2/6/58</u> 22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u> 22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Virginia</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Newlin Jones Wash. D.C.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 6 1958</u>	24b. REGISTRAR'S SIGNATURE <u>John Deacon</u>

EDWARD V. S.

FEB. 6 1958

KELVIN ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Birth wt. 1 lbs 4 oz

226

CERTIFICATE OF DEATH

Reg. Dist. No.

02176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>26</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		d. STREET ADDRESS <i>208 Horner's Lane</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. STREET ADDRESS <i>Baby Boy Keys</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	Fist <i>Baby</i>	Middle <i>Boy</i>	Last <i>Keys</i>	4. DATE OF DEATH Month <i>February</i>	Day Year <i>24 1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 14 1958</i>	9. AGE (in years last birthday) yrs. <i>6</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>.30</i>	Min <i>.30</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Chandler Keys</i>		14. MOTHER'S MAIDEN NAME <i>MILDRED</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Thomas Keys - Father</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i>				INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i>		DUE TO (b) <i>—</i>					
DUE TO (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I attended the deceased from <i>2/24 1958</i> , to <i>2/24 1958</i> , that I last saw the deceased alive on <i>2/24 1958</i> , and that death occurred at <i>3:20 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
SIGNATURE <i>John M. Wyman</i>	M.D.				DATE SIGNED <i>2/24/58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/3/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Rumphay</i>		ADDRESS <i>Bethesda, Maryland</i>	24a. REC'D BY REGISTRAR <i>FEB 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Research</i>		

U.S. GOVERNMENT

TEB - 1973

EXCELSIOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

227 Elm St. 2nd Flr. 225 2-21-58 at
CERTIFICATE OF DEATH

02177

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 shown detached for use of the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Maryland Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Silverbar</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges County</i>	
d. STREET ADDRESS <i>4295 Oak Lane Rd.</i>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HERBERT John King</i>		First	Middle
		Last	4. DATE OF DEATH <i>2 13 1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> February 20 1883 1767 yrs.</i>
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John King</i>		14. MOTHER'S MAIDEN NAME <i>SUSANNAH Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-24-7550</i>	
17. INFORMANT <i>Daughter Mrs Cora F. Bockey Capital Hgt</i>		Address <i>402-579 One</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic Alcoholism</i>			
(b) DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>From the causes and on the date stated above.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rockville Md.</i>		20f. (City or town) (County) (State) <i>Rockville Md. MD</i>	
21. I certify that I attended the deceased from <i>22 Jan 1958</i> to <i>13 Feb 1958</i> , that I last saw the deceased alive on <i>13 Feb 1958</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>509 Hickory Mill Rd.</i>			
ACTUAL SIGNATURE <i>Herman C. Magancini</i>		DATE SIGNED <i>2/17/58</i>	
PHYSICIAN'S NAME (Type) <i>Herman C. MAGANCINI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2/17/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. BARNABAS CEM.</i>		22d. LOCATION (City, town, or county) <i>Oxon Hill, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. C. Jackson, D.C.</i>		ADDRESS <i>1111 Connecticut Ave. N.W.</i>	
		24a. REC'D. BY REGISTRAR DATE <i>Feb 19 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. J. C. Jackson</i>	

DUMEAU V. S.

FEB 19 1973



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2208 CERTIFICATE OF DEATH

02178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cedar Grove		c. LENGTH OF STAY IN lb 1 week		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodfield		e. STREET ADDRESS R.F.D. Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Germantown				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Avondale	Middle King	Lost	4. DATE OF DEATH Feb. 15	Month 1958	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1878	9. AGE (In years lost birthday) 79 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cedar Grove, Md.	
13. FATHER'S NAME Noah Watkins				14. MOTHER'S MAIDEN NAME Julia Linthicum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. W. O. King, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Bronchopneumonia DUE TO (c) Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) Damascus, Md.	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>February 10</u> , 1958, to <u>February 15</u> , 1958, that I last saw the deceased alive on <u>February 14</u> , 1958, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>James P. Kerr</u> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) James P. Kerr DATE SIGNED 2/21/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 22, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Grove	22d. LOCATION (City, town, or county) (State) Woodfield, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u>	ADDRESS Damascus, Md.	24a. REC'D BY REGISTRAR FEB 26 '58	24b. REGISTRAR'S SIGNATURE <u>John E. Bush</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-hospital permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

1900
1901
1902
1903

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

82179

2299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cedar Grove				c. LENGTH OF STAY IN lb years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Germantown				e. STREET ADDRESS R.F.D. Germantown			
3. NAME OF DECEASED (Type or print) Nona Estelle King				4. DATE OF DEATH Feb. 2 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cedar Grove, Md.		9. AGE (In years last birthday) 84 yrs.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Willard Watkins				14. MOTHER'S MAIDEN NAME Charlotte Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs Lottie Good, Silver Spring, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Cervix, met-static 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 13 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized; Secondary anemia; Cong. Ht. F.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1955 , to Feb. 2 1958 , that I last saw the deceased alive on Feb. 1 1958 , and that death occurred at AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Maryland							
ACTUAL SIGNATURE Gilcin E. Meadors, M.D.							
PHYSICIAN'S NAME (Type) Gilcin E. Meadors, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Salem Methodist		22d. LOCATION (City, town, or county) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John L. McIlwraith				24a. REC'D BY REGISTRAR FEB 6 58			
ADDRESS Damascus, Md.				24b. REGISTRAR'S SIGNATURE John L. McIlwraith			

BUREAU V. S.

LS - C - 196



02180

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2210 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
Bethesda	35 days	Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
The clinical Center, Bethesda 14, Md.	Salisbury		
3. NAME OF DECEASED (Type or print)	First William	Middle Alvin	Last King
4. DATE OF DEATH	Month February	Day 8,	Year 19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	December 16, 1928
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Traffic manager		Transportation	Pennsylvania
12. CITIZEN OF WHAT COUNTRY?			
U. S. A.			
13. FATHER'S NAME			
John L. King, Sr.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
Yes WW II		Unascertainable	The Medical Record Address The Clinical Center, Bethesda 14, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency INTERVAL BETWEEN ONSET AND DEATH 3 days			
178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Embryonal cell Carcinoma Primary in Right Testis.			
DUE TO (c) Metastases to lungs, Right Kidney & Inf. Vena Cava. 1 1/4 Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1, 1958, to February 8, 1958, that I last saw the deceased alive on February 8, 1958, and that death occurred at 11:55 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Charles F. Nadler</i>		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) CHARLES F. NADLER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/12/58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <i>Al. French</i>

BUREAU V E

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BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2211 CERTIFICATE OF DEATH

Reg. Dist. No.

112181

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Montgomery</i>				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Silver Spring</i>		<i>6 years</i>		<i>51 Silver Springs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>XAVIERIAN College</i>		<i>10000 New Hampshire Ave.</i>			
3. NAME OF DECEASED (Type or print)	First: <i>Joseph</i>	Middle: <i>J. A. M.</i>	Last: <i>Klinger</i>	4. DATE OF DEATH	Month: <i>Feb</i> Day: <i>9</i> Year: <i>1958</i>
5. SEX	<i>M</i>	6. COLOR OR RACE	<i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
				<i>APRIL 3 - 1908</i>	9. AGE (In years last birthday) <i>71 yrs.</i>
					IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months: <i>0</i> Days: <i>0</i> Hours: <i>0</i> Min: <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Teacher</i>		<i>School</i>		<i>Hazleton Pa</i>	
12. CITIZEN OF WHAT COUNTRY?					
<i>USA</i>					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>Joseph Klinger</i>		<i>MARION Denshock</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				<i>College Friends</i>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>CORONARY Occlusion</i>		<i>In progress</i>	
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>ARTERIO SCLEROTIC (angiokeratoma) disease</i>		1953	
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>PARKINSONISM</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Doy, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 11, 1958</i> to <i>Feb. 5, 1958</i> , that I last saw the deceased alive on <i>9/2, 1957</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	
				DATE SIGNED	
ACTUAL SIGNATURE <i>George P. George</i>				<i>M.D. 9404 Coleridge Rd. S. Springfield</i>	
PHYSICIAN'S NAME (Type) <i>GEORGE P. GEORGE</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-11-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>New CATH. CHURCH</i>	
				22d. LOCATION (City, town, or county) <i>PAWTOWA MD</i>	
				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas F Evans & Son</i>		ADDRESS <i>118 N. Mt. Royal Ave</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 12 1958</i>	
				24b. REGISTRAR'S SIGNATURE <i>John Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2212 CERTIFICATE OF DEATH

Reg. Dist. No.

112182

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 8300 - 16th St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8300 - 16th St..						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD WILLIAM KOCH		First	Middle	Last	4. DATE OF DEATH FEBRUARY 19	Month	Day	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC. 22, 1863	9. AGE (In years last birthday) 94 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Chief, retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Warner A. Koch				14. MOTHER'S MAIDEN NAME Adolphine Gruen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen L. Koch, 8300 - 16th St., Silver Spring.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-01-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				<i>Cocorony Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1950 Feb 19 1958							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4 ADDRESS (Street, city or town, state)	(County)	(State)		
21. I certify that I attended the deceased from _____, 1950, to Feb 19, 1958, that I last saw the deceased alive on Feb 18 1958 , and that death occurred at 7:30 M, from the causes and on the date stated above. J. Marion Bankhead M.D. 9241 Columbia Blvd., Silver Spring 2/19/58									
ACTUAL SIGNATURE J. Marion Bankhead		DATE SIGNED 2/19/58							
PHYSICIAN'S NAME (Type) J. Marion Bankhead									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 22, 1958	22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) SUITLAND, PRINCE GEO. CO., MD.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey,		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR FLB 24 8	24b. REGISTRAR'S SIGNATURE Warren G. Humphrey				
				DATE					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2213 CERTIFICATE OF DEATH

Reg. Dist. No. 02183

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia		d. STREET ADDRESS R.F.D. Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Forest		First T.	Middle Larman	Last	4. DATE OF DEATH Feb. 19	Month 19	Day 58	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1906	9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. MIN 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Building Painter		11. BIRTHPLACE (State or foreign country) Barnesville, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William E. Larman		14. MOTHER'S MAIDEN NAME Catherine R. Smith		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-7231		17. INFORMANT Mrs Mildred Larman, Monrovia, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Immediate						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		DUE TO Arteriosclerotic Heart Disease						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0		DUE TO b)						
		DUE TO c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May , 19 56 , to February , 19 58 , that I last saw the deceased alive on Feb. 12 , 19 58 , and that death occurred at 10 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) W.B. Culwell M.D.					DATE SIGNED 2/21/58	
ACTUAL SIGNATURE W.B. Culwell		NAME (Type) W.B. Culwell						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Damascus Meth.		22d. LOCATION (City, town, or county) Damascus, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Hobson		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE FEB 26 '58		24b. REGISTRAR'S SIGNATURE D. L. Culwell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2214 CERTIFICATE OF DEATH

02184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS #10 Farmington Drive				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Barbara	Middle Willson	Last Lasley	4. DATE OF DEATH	Month February	Day 14	Year 1958
5. SEX		6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1913	9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 10	Days Shephera St.	Hours Chevy Chase, D.C.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Prentiss Willson				14. MOTHER'S MAIDEN NAME Eaith Everett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Robert Neeside				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH one hour				
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Hypertension + Vascular Disease Signs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of Liver								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month Feb.	Day 15	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1629 Columbia Rd.	20f. (City or town) Washington, D.C.	
21. I certify that I attended the deceased from Feb. 15, 1958 to Feb. 14, 1958 , that I last saw the deceased alive on Jan. 30, 1958 , and that death occurred at 7:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state): 1629 Columbia Rd., Wash. D.C.								
DATE SIGNED Charles Wilson Jones								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles Wilson Jones								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Feb. 17, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Ceder Hill		22d. LOCATION (City, town, or county) Suitland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Washington, D.C.				24a. REC'D BY REGISTRAR Feb. 19, 1958		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BONNIE V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2215 CERTIFICATE OF DEATH

02185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Alexandria	
c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS c/o Aldo D'Alessandro 776 Ripley Street	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Bronius	Last Laucka III
4. DATE OF DEATH	Month February	Day 4	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 19, 1946
9. AGE (In years lost birthday) 12 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph B. Laucka		14. MOTHER'S MAIDEN NAME Isabella A. Mocejunas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastric Intestinal hemorrhage with Aspiration INTERVAL BETWEEN ONSET AND DEATH 6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retinoblastoma, sarcoma, metastatic to liver, spleen, lungs (c) Kidneys, intestines, lymph nodes		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 3, 1958 , to February 4, 1958 , that I last saw the deceased alive on February 4, 1958 , and that death occurred at 4:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/5/58			
ACTUAL SIGNATURE <i>Theodore Robinson</i>	M.D.	PHYSICIAN'S NAME (Type) Theodore Robinson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/8/58	22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven	22d. LOCATION (City, town, or county) Silver Spring, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 10 1958	24b. REGISTRAR'S SIGNATURE W. Redden

BUREAU V. S.

FEB 10 1968

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2216

CERTIFICATE OF DEATH

Reg. Dist. No.

02186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emory Grove Rural or Redland		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Delaware	Middle Lee	4. DATE OF DEATH February 8, 1958
5. SEX male	6. COLOR OR RACE <input checked="" type="checkbox"/> C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1879
9. AGE (In years lost birthday) 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman	11. KIND OF BUSINESS OR INDUSTRY Pvt. Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Lee	14. MOTHER'S MAIDEN NAME Sarah Ann Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Ruby Russell. 732 Hobart Pl. N. W. Wash.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Hypertensive Renal Disease			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis Bursitis			19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Norbeck, RFD Silver Spring, Md.
21. I certify that I attended the deceased from Feb. 7, 1958, and that death occurred at 2:30A.M., from the causes and on the date stated above			ADDRESS (Street, city or town, state) Norbeck, RFD Silver Spring, Md.
ACTUAL SIGNATURE Webster Sewell	DATE SIGNED 2/9/58		
PHYSICIAN'S NAME (Type) Webster Sewell	22d. LOCATION (City, town, or county) (State) Falls Church, Va.		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/12/58	22c. NAME OF CEMETERY OR CREMATORIUM First Baptist Church,, Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowdon	24a. ADDRESS Rockville, Md.	24b. REC'D BY REGISTRAR Feb 14 58	24b. REGISTRAR'S SIGNATURE Webster

BRUNAU V. S.

EB 14 1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2108

CERTIFICATE OF DEATH

(12187)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home				d. STREET ADDRESS 9200 River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	Last	4. DATE OF DEATH Feb. 25,	Month	Day	Year 1958	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/72	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 10 Days 18 Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Warren		14. MOTHER'S MAIDEN NAME Annie Duncan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT John C. Leonard-Item # 2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <i>arterial hypertension + fibrilla.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Arteriosclerotic Heart Dis. coronary disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2-3 days Sudden death							
(c) <i>Arteriosclerosis</i>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Broken vertebra - fell on ice</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/13/58</i> to <i>2/23/58</i> , 1958, that I last saw the deceased alive on <i>1/23/58</i> , 1958, and that death occurred at <i>8504</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>500 Undine St NW Wash DC</i>		DATE SIGNED <i>1/27/58</i>	
ACTUAL SIGNATURE <i>Chas H. Wolton</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Chas H. Wolton</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Et. Lincoln		22d. LOCATION (City, town, or county) Prince George Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR FEB 27 '58		24b. REGISTRAR'S SIGNATURE <i>W. A. Redick</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8.11.1998

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2109

CERTIFICATE OF DEATH

Reg. Dist. No. 112188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>13 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitorium & Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>William Lester</i>		d. STREET ADDRESS <i>1880 Manchester Rd.</i>	
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	First <i>William</i>	Middle <i>Stewart</i>	Last <i>Lester</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-19-78</i>
9. AGE (In years last birthday) yrs. <i>79</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher (College Professor)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Miss.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William W. Lester</i>		14. MOTHER'S MAIDEN NAME <i>Savilla Davis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <input type="checkbox"/> If yes, give war or date of service <i>None</i>		16. SOCIAL SECURITY NO <i>none</i>	
17. INFORMANT <i>Washington Sanitorium & Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO <i>421.4</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Decompensation</i> DUE TO (c) <i>Valvular Heart Disease</i>	
		19. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Washington</i> (County) <i>District of Columbia</i> (State) <i>DC</i>	
21. I certify that I attended the deceased from <i>Jan 23, 1958</i> , to <i>Feb 11, 1958</i> , that I last saw the deceased alive on <i>Feb 11, 1958</i> , and that death occurred at <i>1:00 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>918 Elsworth Drive</i> DATE SIGNED <i>2-11-58</i>	
ACTUAL SIGNATURE <i>Philip E. Jones</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>PHILIP E. JONES</i>		22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
22b. DATE THEREOF <i>2/14/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>	
22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MARYLAND</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Humphrey,</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 13 1958</i>	
ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Deborah L. Jones</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2217 CERTIFICATE OF DEATH

02189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda 50da		d. STATE		
c. LENGTH OF STAY IN lb		C. LENGTH OF STAY IN lb		b. COUNTY		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Suburban		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
GENEVIEVE LEMEN				biford	Month Day Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs	
Female White			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 18, 1879	78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
TEACHER		State College		Illinois		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
Albert E. biford		Clara Burge		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
				BROTHER - Harry B. Pumphrey		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		10 days				
442 X		Central hemorrhage				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO				
(b)		Cardio vascular renal disease				
(c)		Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
Extensive degenerative changes involving left supraorbital nerve						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 25, 1957, to Feb. 5, 1958, that I last saw the deceased alive on Feb. 3, 1958, and that death occurred at 6:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE		DUANE C. RICHTMEYER M.D. 1835 Eye St. N.W.				DATE SIGNED 2-5-58
PHYSICIAN'S NAME (Type)		DUANE C. RICHTMEYER Washington 4, D.C.				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		
Cremation		2/6/58		Cedar Hill		
22d. LOCATION (City, town, or county)		Suitland, Maryland (State)				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		
Robert A. Pumphrey-Bethesda, Md.				DATE FEB 10 '58		
VS A15 (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE G. L. G.				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

; 2218 CERTIFICATE OF DEATH

Reg. Dist. No.

02190

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE						
<i>Montgomery</i> MARYLAND		<i>Maryland</i> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<i>Bethesda</i>	<i>hrs.</i>	<i>Damascus</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<i>Suburban</i>	<i>Rt. 2 Box 250.</i>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>Norman Clinton Lynch</i>				2	-	21	1958	
5. SEX	6. COLOR OF FACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH	9. AGE (in years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Male</i>	<i>White</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>July 30 1896</i>	<i>61</i>	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Contractor</i>		<i>Self Employed</i>		<i>D.C.</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>Joseph Lynch</i>		<i>Moose</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
<i>Yes Army W.W. I</i>		<i>578-09-0845</i>		<i>Sister Elsie G. Pond</i>		<i>200 Lawrence St., Burgundy Hills</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Coronary Heart Disease</i>						
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>acute myocardial Infarction</i>						
(b) DUE TO								
(c) Coronary Insufficiency								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from <i>June 19 to Feb 21, 1958</i> , that I last saw the deceased alive on <i>Feb 21, 1958</i> , and that death occurred at <i>6:15 PM</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>4709 Montgomery Lane</i>								
DATE SIGNED <i>Bethesda, MD</i>								
ACTUAL SIGNATURE <i>Paul Clinton</i>		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 26, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elin L. Molesworth</i>		ADDRESS <i>Damascus Md</i>		24a. REC'D BY REGISTRAR <i>Feb 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Debil</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2219 CERTIFICATE OF DEATH										Reg. Dist. No. 02191										
1. PLACE OF DEATH o. COUNTY Montgomery					MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Alabama										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 15 days					b. COUNTY										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mulga										
3. NAME OF DECEASED (Type or print)					First David	Middle Eugene	Last Macon	4. DATE OF DEATH February	Month 24,	Day 19	Year 58	d. STREET ADDRESS None					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 23, 1941		9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS										
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.														
13. FATHER'S NAME Clarence D. Macon					14. MOTHER'S MAIDEN NAME Bertie Mae Wade															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland																
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>										INTERVAL BETWEEN ONSET AND DEATH 3 yrs										
(b) <i>Congenital Aortic Stenosis</i>																				
(c) <i>Congenital</i>																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Acute Pulmonary Edema.</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)										
21. I certify that I attended the deceased from February 9, 1958, to February 24, 1958, that I last saw the deceased alive on February 24, 1958, and that death occurred at 3:00 AM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland										
ACTUAL SIGNATURE <i>Carlos R. Lombardo</i>		M.D.								DATE SIGNED 2/24/58										
PHYSICIAN'S NAME (Type) Carlos R. Lombardo, M. D.		22a. BURIAL, CREMATION, REMOVAL 2/24/58										22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORIY --		22d. LOCATION (City, town, or county) Jasper, Alabama			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St., N.W.										ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR FEB 25 '58		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>						

W. A. V. A.

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1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2220

CERTIFICATE OF DEATH

Reg. Dist. No.

02192

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		9707 Bristol Avenue		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Robert	Middle Main	4. DATE OF DEATH		Month Feb. 23,	Day Year 1958
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/1885		9. AGE (in years by birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Main		14. MOTHER'S MAIDEN NAME Nellie Flynn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) no		16. SOCIAL SECURITY NO. 579-03-0690		17. INFORMANT John G. Main -9707 Bristol Avenue		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 2 days			
		Hypertensive arteriosclerotic Heart Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Vascular Accident					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) February 23	(County) (State)
21. I certify that I attended the deceased from		February 19, 1958, to		February 23, 1958, that I last saw the deceased alive on		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Bernard A. Fitzgerald M.D.		217 University Blvde		DATE SIGNED 2/23/58	
PHYSICIAN'S NAME (Type)		Bernard A. Fitzgerald		Silver Spring, Md.			
22a. BURIAL, CREMATION REMOVAL (Specify) burial		22b. DATE THEREOF 2/25/1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 25 '58		24b. REGISTRAR'S SIGNATURE O. L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician all completely filled in, it should be filed with page 3 detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
; 2221 CERTIFICATE OF DEATH

02193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
MONTGOMERY MARYLAND		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 18 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SuburbAN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. STREET ADDRESS 3624 - SAUL Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE		First 14.	Middle MARLOW
4. DATE OF DEATH 2 - 6 - 58		Month 2	Day 6
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 9 1879		9. AGE (In years lost/birthday) 78 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 2 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Samuel Neely	
14. MOTHER'S MAIDEN NAME Mary Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Mrs. Jane D. Danner 3624 Saul Rd., Kensington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Aneurysm, Abdominal Aorta DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Focal myocardial infarctions		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 750 ft. from home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Maryland		20f. (City or town) (County) Suitland (State) Maryland	
21. I certify that I attended the deceased from March 19, 1958 to Feb. 6, 1958 , that I last saw the deceased alive on Feb. 5, 1958 , and that death occurred at 750 ft. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Marion Bankhead		ADDRESS (Street, city or town, state) 9241 Col. Blvd., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) J. Marion Bankhead		DATE SIGNED 2/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2/8/58	
22c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR FEB 10 '58	
		24b. REGISTRAR'S SIGNATURE A. L. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wrightwell

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מִתְּמִימָנֶלֶת יְסֵדָה

BUREAU V. S.

13



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 & 2 Film 226 2127

12194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb approx. 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 1325 Grandin Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1325 Grandin Avenue				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lorraine		First	Middle	Lost	4. DATE OF DEATH February 12 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1918	9. AGE (in years last birthday) 39	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS Days 19	Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Montg. Co. Police Dept.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0		Alcohol & Carbon monoxide poisoning						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found dead in her home which was afire		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour 10:30 P.M. 2/12 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Rockville	(County) Montg.	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED February 13, 1958						
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/13/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenwood		22d. LOCATION (City, town, or county) Pleasantville, New Jersey		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR FEB 1 1958 DATE 24b. REGISTRAR'S SIGNATURE						

W. A. V. U. M.

850 3 1059



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 112195

DEPUTY MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2110 Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Md.		b. COUNTY MONT. CO.	
Towson Park		D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Washington San. + Hosp.		d. STREET ADDRESS		1752 Silver Spring Ave.	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
Mark Harry			Fuller	Massey	2	8	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-16-1889	68 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
mechanical eng.		Government		Kansas		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Unknown		Massey		unknown		XXXXXX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		560-01-4994		Mrs. Dorothy W. Massey, 752 Silver Spring Ave.		Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____							
DUE TO							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20g. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>2-8-58</u>					
EXAMINER'S NAME (Type) <u>FRANK J Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren G Lumphey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Q. J. ...</u>	

2 JULY 2

CHANCELLOR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02196

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE Maryland b. COUNTY Montgomery	
2229 Bethesda, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. LENGTH OF STAY IN 1b 5416 Huntington Parkway		d. STREET ADDRESS 5416 Huntington Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RICHARD		First	Middle
4. DATE OF DEATH February 18, 1958		Last	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 12/18/58		9. AGE (In years and birthday) 2-19-11 46 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Geo. Ted P. McEntire		14. MOTHER'S MAIDEN NAME Mabel Brooke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Esther S. McEntire same as 2d Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 18, 1958	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.		22b. BURIAL, CREMATION REMOVAL (Specify) Bur-Transit 2/20/58	
22c. DATE THEREOF 2/20/58		22d. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Hope Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		22d. LOCATION (City, town, or county) (State) Shawnee Co., Kansas	
		24e. REC'D BY REGISTRAR FEB 24 1958	
		24f. REGISTRAR'S SIGNATURE <i>John J. Sullivan</i>	

BUREAU V. S.

LB 09 195

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

2223 CERTIFICATE OF DEATH

Reg. Dist. No. 12197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 16 ... 7922 15th Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elwood		First	Middle Rodger	Lost	4. DATE OF DEATH McNutt, Jr.	Month February	Day 20	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1930	9. AGE (In years from birthday) 27 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elwood R. McNutt, Sr.				14. MOTHER'S MAIDEN NAME Myrtle Ryan					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Korean		17. INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric intestinal hemorrhage (massive) INTERVAL BETWEEN ONSET AND DEATH 1 hour									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the colon with metastases 3 mos (c) Ulcerative colitis 21 yrs									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Salmonellosis, hematochezia									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. January 29, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) New Kensington, Pa.		(County) Westmoreland Co.	(State) Penn.
21. I certify that I attended the deceased from January 29, 1958 , to February 20, 1958 , that I last saw the deceased alive on February 20, 1958 , and that death occurred at 11:35 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Donald M. Watkin		M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 2/21/58			
PHYSICIAN'S NAME (Type) Donald M. Watkin, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/21/57		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) New Kensington, Pa.		(State) Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR FEB 24 '58		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

RECEIVED
BUREAU OF

FEB 24 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12198

2224 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6005 Ryland Drive				e. STREET ADDRESS 6005 Ryland Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Elizabeth Mary Menkert		First	Middle	Last	4. DATE OF DEATH Feb. 2 1958	Month	Day	Year						
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/7/79	9. AGE (In years lost birthday) 78 yrs	10. IF UNDER 1 YEAR Months 10 Days 25	11. IF UNDER 24 HRS Hours 25 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Coffee & Tea		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Conrad C. Eber				14. MOTHER'S MAIDEN NAME Sophia Aigler										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edna Holloran, sister		Address same as 2d								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Coronary Occlusion with Myocardial Infarction</i> <i>Essential Hypertension</i> <i>Generalized Arteriosclerosis</i>									INTERVAL BETWEEN ONSET AND DEATH 1 day years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>6/1/54</i>							20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>2/2/58</i>	20f. (City or town) <i>10620 Georgia Ave</i>	(County) <i>Silver Spring, Md</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>6/1/54</i> to <i>2/2/58</i> , that I last saw the deceased alive on <i>2/2/58</i> , and that death occurred at <i>5:15 p.m.</i> from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>10620 Georgia Ave Silver Spring, Md</i>		DATE SIGNED <i>John J. Curry M.D. 2/2/58</i>			
ACTUAL SIGNATURE <i>John J. Curry</i>		PHYSICIAN'S NAME (Type) John J. Curry												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/58		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Baltimore		22e. (State) Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland												
VS A15 (4) 1SM 10/57		24a. REC'D BY REGISTRAR FEBS '58							24b. REGISTRAR'S SIGNATURE <i>Alv. Finch</i>					

REAU Y. A.

3 2 1 0

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

021991

2111 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland.</i>		b. COUNTY <i>Prince George's Co.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park Md.</i>		c. LENGTH OF STAY IN lb <i>DOA.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		d. STREET ADDRESS <i>2010 Drexel St</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Surg. Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>John McNeash</i>		First <i>John</i>	Middle <i>McNeash</i>	Last <i>(Inskip)</i>	4. DATE OF DEATH <i>2/16/58</i>	Month <i>2</i>	Day <i>16</i>	Year <i>1958</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-29-10</i>		9. AGE (In years last birthday) <i>47 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver for Bakery</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		
13. FATHER'S NAME <i>William Thomas Neushout</i>		14. MOTHER'S MAIDEN NAME <i>Edith Dingee</i>						
15. WAS EVER SERVED IN U. S. ARMED FORCES? [Yes, no, or unknown] <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>few seconds</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.] <i>Coronary artery heart disease 2 1/2 yrs</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Feb 15 1955</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 705 Ridge Rd Adele</i>		20f. (City or town) (County) (State) <i>Ridge Rd Adele</i>		
21. I certify that I attended the deceased from <i>1955</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Feb 15 1957</i> , and that death occurred at <i>705 Ridge Rd Adele</i> . ACTUAL SIGNATURE <i>Robert B. Irey Jr.</i> ADDRESS (Street, city or town, state) <i>705 Ridge Rd Adele</i> DATE SIGNED <i>1958</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-19-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Crown Hill</i>		22d. LOCATION (City, town or county) (State) <i>Bel Air Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Lee & Sons</i>		ADDRESS <i>300 N. 4th St. Bel Air Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John Lee</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

the water in the soap
is not well enough

the water is not
well enough for it to be
used for soap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 on 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2225

CERTIFICATE OF DEATH

Reg. Dist. No.

02200

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Montgomery		b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 3 Da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS 7-Russell Ave									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Anne		First	Middle Irene	Last Meyer	4. DATE OF DEATH Feb 16	Month	Day	Year 1958							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 6th 1920	9. AGE (In years last birthday) 37 yrs	IF UNDER 1 YEAR 6	IF UNDER 24 HRS 10	Months	Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keepin'		10b. KIND OF BUSINESS OR INDUSTRY Home work		11. BIRTHPLACE (State or foreign country) Newport News, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Henry L. Meyer				14. MOTHER'S MAIDEN NAME Anne Georgia Kubule		Address Henry L. Meyer, Gaithersburg, Md.									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO NEPHROSCLEROSIS (c) ACUTE RENAL FAILURE					INTERVAL BETWEEN ONSET AND DEATH 3 DAYS				
											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 15 yrs.				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DIABETES MELLITUS		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 26 N. SUMMIT AVE	20f. (City or town) Gaithersburg	(County) Montgomery	(State) Md.		
21. I certify that I attended the deceased from _____		alive on _____		13 Feb 1958		to _____		16 Feb 1958		That I last saw the deceased and that death occurred at 3:25 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Gordon S. Rosenberg, Jr.		DATE SIGNED 17 Feb 1958	
ACTUAL SIGNATURE Gordon S. Rosenberg, Jr.		PHYSICIAN'S NAME (Type) Gordon S. Rosenberg, Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-58		22c. NAME OF CEMETERY OR CREMATORIAL Forest Oak Cemetery		22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 21 '58		24b. REGISTRAR'S SIGNATURE L. J. Deasey									

PAU V. 2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2112 CERTIFICATE OF DEATH

Reg. Dist. No. 02201

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>1290½ Grenoble Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Infant</i>		First <i>Girl</i>	Middle <i>Miller</i>	4. DATE OF DEATH <i>February 16, 1958</i>	Month <i>February</i>	Day <i>16</i>	Year <i>1958</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 16, 1958</i>	9. AGE (In years lost birthday) yrs. <i>0</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Robert David Miller</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Jane Eilers</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ATELECTASIS OF LUNGS</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <i>16 Feb</i> , 19 <i>58</i> , to <i>16 Feb</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>16 Feb</i> , 19 <i>58</i> , and that death occurred at <i>3:15 P.M.</i> , from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Francis J. Troendle</i>		M.D.		ADDRESS (Street, city or town, state) <i>809 Viers Mill Road, Rockville, Md.</i>		DATE SIGNED <i>17 Feb '58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>2-20-58</i>		22c. NAME OF CEMETERY OR CREMATORIALy <i>Hosp. Washington Sanitarium and</i>		22d. LOCATION (City, town, or county) <i>Takoma Park, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Ware M.D. Washington Sanitarium Hospital</i>		ADDRESS <i>O'Hospital</i>		24a. REC'D BY REGISTRAR <i>Robert Ware M.D.</i>		24b. REGISTRAR'S SIGNATURE <i>Robert Ware M.D.</i>		

BUREAU V. E.

FEB 24 1958

RECEIVED
LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2226

CERTIFICATE OF DEATH

02202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 1911 ROOKWOOD ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1911 ROOKWOOD ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELSIE	Middle ANNA	Last MILLER	4. DATE OF DEATH FEB.	Month 13	Doy Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/11/94	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT F. GRAFF				14. MOTHER'S MAIDEN NAME JULIA UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NO. <u>NONE</u>		17. INFORMANT Mr. Harry L. Miller, Jr., 1911 Rookwood Road		Address Silver Spring, Maryland, between onset and death 3 months	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA</u> or THE AMERICAS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9013 FLORIDA AVE.		(County)	(State)
21. I certify that I attended the deceased from <u>Sept. 17, 1954</u> to <u>Oct. 13, 1958</u> , that I last saw the deceased alive on <u>Oct. 12, 1958</u> , and that death occurred at <u>S.A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.B. Snow</u> ADDRESS (Street, city or town, state) M.D. <u>9013 FLORIDA AVE., SILVER SPRING, MD.</u> DATE SIGNED <u>4/13/58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 2/13/58		22c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CREMATORIUM		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner & Kumpfrey</u>				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB. 13/58	
						24b. REGISTRAR'S SIGNATURE <u>such</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. If the certificate has been detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LEADER V. S.

C. 3 1953



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death - Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9
2227

CERTIFICATE OF DEATH

02203
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 53 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS c 8 X - 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Edgar	Middle O'Neal	Last MOOSE	4. DATE OF DEATH February 16	Month Day Year 19 58	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 23 January 1910	9. AGE (in years last birthday) 86 48 yrs.	10. IF UNDER 1 YEAR Months 06	11. IF UNDER 24 HRS Days 48
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Edgar MOOSE			14. MOTHER'S MAIDEN NAME Cardilia White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 3-13-31 to 11-9-37		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Sarah Creola Moose (Same As #2)		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Caranoma of The Lung						INTERVAL BETWEEN ONSET AND DEATH about
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 December, 19 57 , to 16 February, 19 58 , that I last saw the deceased alive on 15 December, 19 58 , and that death occurred at 10:45A M, from the causes and on the date stated above						ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.
ACTUAL SIGNATURE Jerome A. Gold						DATE SIGNED 2-17-58
PHYSICIAN'S NAME (Type)		U.S. Naval Hospital, Bethesda, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hunt & Ryan Funeral Home, Waldorf, Maryland		ADDRESS Elmwood Funeral Home		24a. REC'D BY REGISTRAR DATE FEB 19 '58		24b. REGISTRAR'S SIGNATURE W. E. E. M.

PUNEAU V. S.

REG. U. S. PAT. OFF.

FEB 1 1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2228 CERTIFICATE OF DEATH

(12204)

Reg. Dist. No.

Tunis

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
MONTGOMERY MARYLAND		Maryland Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda	6 hours	Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
SUBURBAN HOSPITAL		9041 Manchester Rd.			
3. NAME OF DECEASED (Type or print)	First Boy	Middle MORRIS	4. DATE OF DEATH Month Feb. Day 15 Year 1958		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15 1958		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		
			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Arthur C. Morris	14. MOTHER'S MAIDEN NAME Mildred Fink		Address MOTHER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) '116 X Pre maturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Feb. 15, 1958, to Feb. 15, 1958, that I last saw the deceased alive on Feb. 15, 1958, and that death occurred at 4 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Michael L Buckley (M.D.) 4636 Montgomery Ave. Bethesda ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Michael L Buckley					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2-21-58	22c. NAME OF CEMETERY OR CREMATORIUM Suburban Hospital	22d. LOCATION (City, town, or county) Bethesda, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 3 '58	24b. REGISTRAR'S SIGNATURE Silverman		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHIREAU V. S.

MAR 3 1960

POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2229

CERTIFICATE OF DEATH

Reg. Dist. No.

02205

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			
d. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 3407 43rd Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gilbert Thomas Morrison, Jr.		First Middle Last	4. DATE OF DEATH February, 10, 1958		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> January 4, 1947	9. AGE (In years last birthday) 11 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert T. Morrison, Sr.		14. MOTHER'S MAIDEN NAME Mable Costlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 289.2 DUE TO <i>Hippocratic Pulmonary Hemosiderosis</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from February 8, 1958, to February 10, 1958, that I last saw the deceased alive on February 10, 1958, and that death occurred at 1:35 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>The Clinical Center</i> DATE SIGNED 2/10/58					
ACTUAL SIGNATURE <i>Charles B. Neal, M.D.</i>		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Gasch's Sons</i>		ADDRESS Hyattsville Maryland.	24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Nease</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U. S.

-EB 10 1968

SEARCHED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2230 CERTIFICATE OF DEATH

Reg. Dist. No. 212206

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 63 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2825 Overland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herbert Franklin		First	Middle	Last	4. DATE DEATH	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MOSELEY 17 January 1888	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Allan MOSELEY				14. MOTHER'S MAIDEN NAME Lillian REEVES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I and WW2		17. INFORMANT (Wife) Mrs Virginia May Moseley (Same as #2)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) generalized metastases						INTERVAL BETWEEN ONSET AND DEATH 10/1X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma - head of pancreas		DUE TO 5 months							
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1 December, 1957 , to 2 February, 1958 , that I last saw the deceased alive on 2 February, 1958 , and that death occurred at 12:50PM , from the causes and on the date stated above								ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Bruce H. Rice								DATE SIGNED 2-4-58	
PHYSICIAN'S NAME (Type) Bruce H. Rice, LT, MC, USN				U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 1400 Chapin St. Washington, D.C.		24a. REC'D BY REGISTRAR FEB 8 '58		24b. REGISTRAR'S SIGNATURE (R.W. Chambers)			

BUREAU V. S.

10
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2113 CERTIFICATE OF DEATH

Reg. Dist. No.

112207

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 1915 Glen Ross Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Edgar	Middle A.	Last Nelson	4. DATE OF DEATH Feb. 15	Month	Day	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/1874	9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -- U.S. Government - Census Bureau		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar A. Nelson			14. MOTHER'S MAIDEN NAME Aureilla Freeman			Address Chevy Chase, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert E. Phelps - 3707 Leland Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 12, 1958, to Feb. 15, 1958, that I last saw the deceased alive on Feb. 12, 1958, and that death occurred at 10:15 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE J. Marion Bankhead MD 9241 Col. Blvd DATE SIGNED 2/14/58 PHYSICIAN'S NAME (Type) J. Marion Bankhead Silver Spring, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE C. A. Hines	

BUREAU V. &

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REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-12, 22, 31-8 et

02208

2231

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE b. COUNTY	
hight jersey MARYLAND		North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
Bethesda		New Bern	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		STREET ADDRESS	
Emory		714 Second Street	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Eva		Land	Nelson
4. DATE OF DEATH		Month	Day
5. SEX		1802	1958
Female		9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
6. COLOR OR RACE		Months	Days
White		12	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH	Hours
		December 24, 1918	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign/country)	
Homemaker		North Carolina	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas J. Land		Margaret Brinsford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
None		Son-in-law, Ernest W. Brown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4 hours	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Myocardial infarction	
DUE TO		12 hours.	
(b)		Coronary artery occlusion	
DUE TO		12 hours.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
		(County) (State)	
21. I certify that I attended the deceased from 5 Feb., 1958, to 6 Feb., 1958, that I last saw the deceased alive on 6 Feb., 1958, and that death occurred at 7:50 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
		DATE SIGNED	
ACTUAL SIGNATURE		Seruch T. Kimble M.D. 929 Pershing Drive, Silver Spring, Md.	
PHYSICIAN'S NAME (Type)		929 Pershing Drive S. S.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		2/10/58	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Cedar Grove		New Bern, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Robert A. Pumphrey Bethesda, Maryland		DATE FEB 15 1958	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1959

DE SERVÉE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02209

2232 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN lb RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glen Echo				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clara Barton House, Oxford St.		d. STREET ADDRESS Oxford Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Josephine		First Eloise	Middle Noyes	4. DATE OF DEATH February 27 1958	Month February	Day 27	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/11/1881	9. AGE (In years lost birthday) 76 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gott-Debt of Agric.		10b. KIND OF BUSINESS OR INDUSTRY Food manager		11. BIRTHPLACE (State or foreign country) Wyoming, Iowa		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Sylvester George Franks		14. MOTHER'S MAIDEN NAME Huldah Jane Lytton		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 579-03-6134		17. INFORMANT Mrs. Katharine Bronson same as 2d				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X		DUE TO cerebro-vascular accident		INTERVAL BETWEEN ONSET AND DEATH 2 months				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO arteriosclerosis						
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from December 25, 1957 , to February 27, 1958 that I last saw the deceased alive on February 27, 1958 , and that death occurred at 4 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 1801 Eye St. N.W., Wash. D.C. 2/27/58						DATE SIGNED
ACTUAL SIGNATURE Alban W. Eger								
PHYSICIAN'S NAME (Type) Alban W. Eger								
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Ransit 3/1/58		22b. DATE THEREOF 3/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Wyoming Cemetery		22d. LOCATION (City, town, or county) Wyoming, Iowa		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Mar 2 '58		24b. REGISTRAR'S SIGNATURE Quinn		

MURRAY V. S.

MAR 3 1966

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2114

CERTIFICATE OF DEATH

Reg. Dist. No.

(1221)

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>TAKOMA PARK</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WASHINGTON SANATORIUM & Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>1905 DAVIS AVE</i>	
3. NAME OF DECEASED (Type or print) <i>DAVID WAYNE OLSON</i>		4. DATE OF DEATH <i>FEB. 15 1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 14, 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>TAKOMA PARK, Md.</i>
13. FATHER'S NAME <i>DAVID JACK OLSON</i>		14. MOTHER'S MAIDEN NAME <i>FRANCES ANELIA RUSSELL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>DAVID JACK OLSON 1905 DAVIS AVE., TAKOMA PARK, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		alive on _____	
ACTUAL SIGNATURE <i>Herbert D. Glick</i>		DATE OF DEATH <i>2-14-1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 19, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cemetery</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW DC</i>		24a. ADDRESS <i>ADDRESS</i>	24b. REC'D BY REGISTRAR DATE <i>REC'D JU 1 1958</i>
		24c. REGISTRAR'S SIGNATURE <i>S. L. H.</i>	

ENDAY Y. 6

FEB 18 1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233 CERTIFICATE OF DEATH

Reg. Dist. No. 12211

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE	
<i>Henderson</i> Maryland		<i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Silver Spring</i>		d. STREET ADDRESS <i>1921 East West Highway</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Henderson</i>	Last <i>Durand</i>
4. DATE OF DEATH	Month <i>2</i>	Day <i>13</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 7, 1881</i>
9. AGE (In years last birthday) <i>76</i>	10. IF UNDER 1 YEAR Months <i>4</i>	11. IF UNDER 24 HRS Days <i>1</i>	12. IF UNDER 24 HRS Hours <i>0</i>
13. IF UNDER 24 HRS Min. <i>0</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Patent office</i>		
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Charles Durand</i>		14. MOTHER'S MIDDLE NAME <i>Elizabeth Henderson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Former Daughter-in-Law</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis & left hemiplegia</i> DUE TO <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Bronchopneumonia, rt. long base</i>	
DUE TO <i>—</i>		(b) <i>Cerebral Arteriosclerosis</i>	
(c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchopneumonia, rt. long base</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Jan 28</i> , 1958, to <i>Feb 13</i> , 1958, that I last saw the deceased alive on <i>Feb 13</i> , 1958, and that death occurred at <i>650 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3921 Ingomar St N.W. 2.14.58</i>			
ACTUAL SIGNATURE <i>Stewart Clapp</i>		DATE SIGNED <i>—</i>	
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>		M.D. <i>—</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/17/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. H. Kline Co. 2901-14th St. N.W.</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
VS A15 (4) 1SM 9/55		DATE <i>FEB 19 '58</i>	

Y. S.
1933
JULY 12
BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2234 CERTIFICATE OF DEATH

(12212)

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 6 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda Md.		e. STREET ADDRESS 1505 Otis Street NE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Eugene PAYNE		First	Middle	Last	4. DATE OF DEATH Month Day Year February 26 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH 18 December 1896	9 AGE (In years last birthday) 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service, District of Columbia		10b. KIND OF BUSINESS OR INDUSTRY of Columbia		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Wilbur PAYNE			14. MOTHER'S MAIDEN NAME Mildred MASON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes, give year or dates of service Yes 8-28-17 to 6-20-18		16. SOCIAL SECURITY NO. 578-18-8731		17. INFORMANT (Wife) Mrs. Dorothy L. Payne (Same As #2)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH unknown					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 February, 1958 , to 26 February 1958 , that I lost the deceased alive on 26 February, 1958 , and that death occurred at 9:40A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>C.U. Shilling</i> M.D. U.S. Naval Hospital, Bethesda, Md. 2-26-58					
PHYSICIAN'S NAME (Type) C.U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b DATE THEREOF 2-28-58 3-3-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	
				22d LOCATION (City, town, or county) Arlington, Virginia	
23 FUNERAL DIRECTOR'S SIGNATURE <i>P.J. Saffell</i>		ADDRESS P.J. Saffell, 5th & "H" St., N.W. Wash. D.C.		24a REC'D BY REGISTRAR DATE FEB 27 '58	
				24b. REGISTRAR'S SIGNATURE <i>John Saffell</i>	

5 X 7 1/2

8 / 1933

REALESTATE

(12213)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS Chestnut St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frances Louise Peach		First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year	
5. SEX female		6 COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/6/1956	9. AGE (In years last birthday) 2 yrs	IF UNDER 1YR Months	IF UNDER 24 HRS Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Norman Peach		14. MOTHER'S MAIDEN NAME Estel Anderson		Address Norman Peach, New Market, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burn involving head body & extremities DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Found dead in burning home							
20c. TIME OF INJURY Month, Day, Year Hour 2:40 p.m. 20d. INJURY OCCURRED While at work Not while at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Gaithersburg		(County) Montg.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/8/58			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Simpson Chapel Damascus, Md.		22d. LOCATION (City, town, or county) New Market, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McLeveth				24a. REC'D BY REGISTRAR DATE FEB 11 1958		24b. REGISTRAR'S SIGNATURE John J. Smith			

3 A DAY



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2236 CERTIFICATE OF DEATH

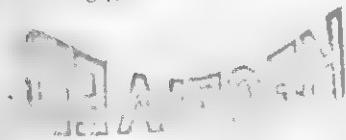
02214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRNG		c. LENGTH OF STAY IN lb 18 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRNG		d. STREET ADDRESS 734 UNIVERSITY BLVD., EAST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 734 UNIVERSITY BLVD., EAST				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Walter	Last Peed, JR.	DATE OF DEATH FEB.	Month 26	Day 19 Year 58
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 6/20/93	9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisory Purchasing Agent U.S. Gov't.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME JOSEPH WALTER PEED				14. MOTHER'S MAIDEN NAME ADDIE VIRGINIA NEALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marguerite G. Peed, 734 University Blvd., E. Silver Spring, Md.			
YES WW #1		none		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X				INTERVAL BETWEEN ONSET AND DEATH 15-18 mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cancer of the head of the pancreas and probable metastases							
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from last 10 years to 2/26/58, 19, that I last saw the deceased alive on 2/26, 19 58, and that death occurred at 12110A M, from the causes and on the date stated above. ACTUAL SIGNATURE Chas. H. Wolohan, M.D.		ADDRESS (Street, city or town, state) 500 Underwood St., N.W., Washington, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/28/58		22c. NAME OF CEMETERY OR CREMATORIUM ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Warren G. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR T. E. D.		24b. REGISTRAR'S SIGNATURE John J. Murphy	
VS A15 (4) 15M 9/55		DATE		DATE		DATE	

BURKHAU V. C

FEB



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02215

2237 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Claggettsville		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2 Monrovia, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillie	Middle May	Last Perkinson	4. DATE OF DEATH	Month February	Day 21	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1885	9. AGE (in years from birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Webster Moxley				14. MOTHER'S MAIDEN NAME Mary M. Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Albert W. Perkinson, Rt. 2 Monrovia, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		DUE TO (b) Arteriosclerotic cardiovascular disease		DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH 1 weeks	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 10, 1958 to 2/21 , 1958, that I last saw the deceased alive on 5/19, 1958 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 2/23/58							
ACTUAL SIGNATURE James P. Kerr M.D.							
PHYSICIAN'S NAME (Type) Dr. James Kerr Damascus, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORIUM Montgomery Meth.		22d. LOCATION (City, town, or county) Montgomery Chapel, Mont., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATED FEB 22 1958	
						24b. REGISTRAR'S SIGNATURE Alfred E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shown detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. A. C. M.

83



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2238

CERTIFICATE OF DEATH

02216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRNG		c. LENGTH OF STAY IN 1b 1 yr. 1 month		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA REST HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		f. STREET ADDRESS 1901 Henderson Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAUDE	Middle S.	Last POHZEL	4. DATE OF DEATH FEB. 14,	Month 1958	Day 14,	Year 1958		
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 6/15/77	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor of Rooming House				11. BIRTHPLACE (State or foreign country) Woodstock, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT WILKIN				14. MOTHER'S MAIDEN NAME ANN R. HAMMOND				Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Andrew Miller, 1901 Henderson Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)				Silver Spring, Maryland BETWEEN ONSET AND DEATH one wk					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 2205 Richland St., Silver Spring, Md.	(County) 2205 Richland St., Silver Spring, Md.	(State) 2205 Richland St., Silver Spring, Md.			
21. I certify that I attended the deceased from 2-3-1957 to 2-14-1958 , that I last saw the deceased alive on 2-9-1958 , and that death occurred at 1:00 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Harry J. Kicherer M.D. 2205 Richland St., Silver Spring, Md. 2/14/58 PHYSICIAN'S NAME (Type) HARRY J. KICHERER									
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 2/17/58		22c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL		22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND		(State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warren B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 21 1958		24b. REGISTRAR'S SIGNATURE G. L. Morris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LUREAU V. S.

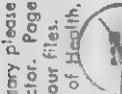
TE3 1003



112217

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

3. NAME OF DECEASED
(Type or print) James L. POWERS 4. DATE OF DEATH February 19, 1958

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED 8. DATE OF BIRTH April 30, 1906 9. AGE (in years
lost birthday) 51 yrs.

Male White WIDOWED Newfoundland IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.

10a. USCL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)

Contractor Own business Newfoundland 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME James Powers 14. MOTHER'S MAIDEN NAME Clara Tobin Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT

No Unknown Selma C. Powers, same as 2d

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN
ONSET AND DEATH sudden

4. DUE TO
Conditions, If any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b) _____
DUE TO
(c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour
o. m.
p. m. 19 While at work Not while at work

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE Frank J. Broschart DATE SIGNED

EXAMINER'S
NAME (Type) Frank J. Broschart, M.D. M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, OR REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Cremation 2/21/58 Cedar Hill Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey Bethesda, Maryland DATE FEB 24 '58 [Signature]

VS. A15ME
SM 2 57

BUREAU V.

FEB 04 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2240 CERTIFICATE OF DEATH

Reg. Dist. No. 215

102218

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakton		d. STREET ADDRESS Rural Route #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Stephen	Middle Ewing	Last RICE	4. DATE OF DEATH February 9 1958	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 1905	9. AGE (in years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours	IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney Lawyer Judge		10b. KIND OF BUSINESS OR INDUSTRY Court U.S.Tax		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Stephen E. RICE		14. MOTHER'S MAIDEN NAME Carolyn FLOYD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT (Wife) Mrs. Lida J. RICE (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1		Cerebral neoplasm (probable)				1 month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Metastatic bronchogenic carcinoma				6+ month	
(c)							
DUE TO							
DUE TO							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 27 January 1958 to 9 February 1958 , that I last saw the deceased alive on 9 February 1958 , and that death occurred at 7:25 P.M. from the causes and on the date stated above							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE <i>R.G. Galbraith, Jr.</i>							
M.D. U.S. Naval Hospital, Bethesda, Md. 2-10-58							
PHYSICIAN'S NAME (Type) R.G. GALBRAITH, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DEMAIN'S</i>		ADDRESS 520 S. Washington St. Alexandria, Va.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>G. J. Reisch</i>	

СУХЛАН В. А.
БИОЛОГИЧЕСКИЙ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 FilmG225 2-1-59 et
2115 CERTIFICATE OF DEATH

(12219)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C.		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON					
d. NAME OF HOSPITAL (If not in hospital, give street address) Oak Haven Nursing Home				d. STREET ADDRESS 7104 CHESTNUT ST. NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANNIE		First W	Middle S.	Last RICHARDS.	4. DATE OF DEATH FEB. 11, 1958.	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15, 1876	9. AGE (In years from birthday) 81 yrs	IF UNDER 1 YEAR Months	Days	Hours	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during past 6 months, i.e., even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) -----		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Woods		14. MOTHER'S MAIDEN NAME Fannie Sullivan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Harry Richards		Address 7125 Piney Branch Rd. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		Carcinoma of Rectum		INTERVAL BETWEEN ONSET AND DEATH 2 years.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6940 PINEY BRANCH RD. N.W.		(County)	(State)
21. I certify that I attended the deceased from Jan. 13, 1958 to Feb. 11, 1958 , that I last saw the deceased alive on Feb. 11, 1958 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) WASH. 12, D.C.					
ACTUAL SIGNATURE lynwood Feiges		M.D.		DATE SIGNED 2-11-58					
PHYSICIAN'S NAME (Type) LYNWOOD FEIGES, M.D., F.A.C.A.									
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation 2/12/58		22b. DATE THEREOF 2/12/58		22c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) Prince George, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR FEB 13 '58		24b. REGISTRAR'S SIGNATURE C. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

500

WASHINGTEN

118 - 24th & 2nd St.

118-24th

RICHARDS

Ao 12, 1958

THE VANDALS

M

H

(REGISTRATION NO. 112515)

X

1

REGISTRATION NO. 112515
RICHARDS, RICHARD
118-24th & 2nd St.
WASHINGTEN D.C.
A.D. 12.1958

JOHN
WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2116 CERTIFICATE OF DEATH

02220

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b	b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 Philadelphia Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		
3. NAME OF DECEASED (Type or print) Lilian A		First	Middle	Last
4. DATE OF DEATH February 20		Month	Day	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/9/1875	9. AGE (In years less birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY New Hampshire		11. BIRTHPLACE (State or foreign country) Caroline
12. CITIZEN OF WHAT COUNTRY? Elizabeth Stearns				
13. FATHER'S NAME David A. Ritter		14. MOTHER'S MAIDEN NAME Mary Evelyn Bakhsh-1636 Kenyon St. N.W.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Address Washington, DC	17. INFORMANT Washington, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>William D. Aud</i> M.D. ADDRESS (Street, city or town, state) <i>906 Elmsdale Rd Silver Spring, Md</i> DATE SIGNED <i>2/20/58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/58	22c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery	22d. LOCATION (City, town, or county) Washington, D.C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR FEB 24 58	24b. REGISTRAR'S SIGNATURE (Signature)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K

3 94 1958

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2241 CERTIFICATE OF DEATH

Reg. Dist. No. 112221

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE	
MONTGOMERY MARYLAND		MD	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
SILVER SPRING-		MONTGOMERY	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
8602 - 11 th Ave -			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
EMILY	C.	ROSE	4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	JUN. 25, 1873
9. AGE (In years last birthday) years	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		WASH. D.C.	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
VINCENT BURCH	MARY C. PENN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		WALTER H. COOPER - 8602 Silver Spring Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident - recurrent</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>Oct 10</i> , 1953, to <i>Feb 10</i> , 1958, that I last saw the deceased alive on <i>Feb 10</i> , 1958, and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL		ADDRESS (Street, city or town, state)	
<i>Ernest A. Barao</i>		M.D. 7006 New Hampshire Ave	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
<i>Ernest A. Barao</i>		2/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Feb. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Arlington Nat.		Arlington VA	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>J.W. Lee Son</i>		24b. REGISTRAR'S SIGNATURE	
Wash. D.C.		DATE: Feb 13 '58	
VS A15 (4)		ALL INFORMATION	
15M 10/57			

LAUREN V. S.

FEB 18 1953

REGGAE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2117 CERTIFICATE OF DEATH

Reg. Dist. No. 03585

1. PLACE OF DEATH o COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium</i>		d. STREET ADDRESS <i>410 Nicholson St NW</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Soda</i>	Middle <i>Rosenthal</i>	4. DATE OF DEATH <i>Feb 11 1958</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/15-1895</i>
9. AGE (In years last birthday) <i>63 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housedentics</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Wm</i>		14. MOTHER'S MAIDEN NAME <i>Sylvia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>519-48-4767</i>	17. INFORMANT <i>Stanley Rosenthal 414 Jefferson NE</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Adenocarcinoma of cecum</i>		UNKNOWN	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cessation by extension</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 10, 1957</i> , to <i>Feb 11, 1958</i> , that I last saw the deceased alive on <i>Feb 10, 1958</i> , and that death occurred at <i>4:16 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>533 Ridge Rd N.W. Washington D.C.</i>	
ACTUAL SIGNATURE <i>Arthur S. Bresler</i>		DATE SIGNED <i>2-11-58</i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR S. BRESLER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 2/12-1958</i>		22b. DATE THEREOF <i>2/12-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Cemetery</i>
22d. LOCATION (City, town, or county) (State) <i>Washington DC</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 10 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Bresler</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EAU V. S.

MR 16 1003

ELVIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2242 CERTIFICATE OF DEATH

112222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb 18 Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON, D.C.		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANITARIUM		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		f. STREET ADDRESS 3900 16th St., N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rachelle		First	Middle	Last	4. DATE OF DEATH 2 28 1958	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/22/1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EDWARD PRAGER				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT KURT E. ROSINGER, 3900 16th St., N.W., D. C.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 7 WKS.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. —		(b) DUE TO Cerebral Atherosclerosis				8 yrs			
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Syndrome, Atherosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) SUITLAND, MD.	(County)	(State)	
21. I certify that I attended the deceased from 6-3 1954 to 2-28 1958 , that I last saw the deceased alive on 2-27 1958 , and that death occurred at 9:55 AM , from the causes and on the date stated above		ADDRESS (Street, city or town, state) 3729 Morrison St., N.W., Wash. 15, D.C. DATE SIGNED Thomas A. Wildman M.D.							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) THOMAS A. WILDMAN		3729 MORRISON ST., N.W., WASH. 15, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 2/28/1958		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		22d. LOCATION (City, town, or county) SUITLAND, MD. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler, Jr.		ADDRESS 1756 Pa. Ave., N.W., D.C.		24a. REC'D BY REGISTRAR DATE MR 3 '58		24b. REGISTRAR'S SIGNATURE Albert J. Smith			

BUKEAU V. S.

MAR 3 1963



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2243

CERTIFICATE OF DEATH

Reg. Dist. No.

112223

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville-Rural		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Philomenas Rest Home, 16901 Ga. Ave		d. STREET ADDRESS 3109 Winden Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Gena		First	Middle	Losl	4. DATE OF DEATH Feb 25	Month	Day	Year		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6 1873		9. AGE (In years lost birthday) 84 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S				
13. FATHER'S NAME George Frye		14. MOTHER'S MAIDEN NAME Sarah Cuffman		Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Norman Ryman, 3109 Winden Rd. Mt. Rainier, Md		INTERVAL BETWEEN ONSET AND DEATH 24 hr				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease DUE TO (d) Generalized Arteriosclerosis										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)		
21. I certify that I attended the deceased from 2-2-1958 to 2-25-1958 , that I last saw the deceased alive on 2-2-1958 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Harry J. Kucherer, M.D.		ADDRESS (Street, city or town, state) 2205 Richardson St., Silver Spring, Md. DATE SIGNED								
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) Beallsville, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville, Md.		ADDRESS DATE FEB 28 '58 REG'D BY REGISTRAR REGISTRAR'S SIGNATURE Asst. Secy.								

BUREAU V. A.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02224

2244 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		c. LENGTH OF STAY IN 1b 18yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove	
3. NAME OF DECEASED (Type or print) First Girtrude Middle Lay Last Rynex		4. DATE OF DEATH Month Feb Day 7th Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 28-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	11. BIRTHPLACE (State or foreign country) Indiana
13. FATHER'S NAME George Robenson		14. MOTHER'S MAIDEN NAME Mary D. Azbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	17. INFORMANT Frank Allen Rynex, Washington Grove, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO BACTERIAL AND BACILLUS CLOSTRIDIUM 5 DAYS		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CERT-BACTERIAL HEMORRHAGE 21 DAYS			
(c) HYPERTENSIVE HYPERTROPHIC CARDIOPATHY 20 years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB 7, 1958, to FEB 7, 1958, that I last saw the deceased alive on FEB 7, 1958, and that death occurred at 10:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Gordon S. Rosenberger M.D. ADDRESS (Street, city or town, state) 26 N. Summit Ave. Gaithersburg, Md. DATE SIGNED FEB 7, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-58	22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak
22d LOCATION (City, town, or county) (State) Gaithersburg, Md.		24a. RECEIVED BY REGISTRAR FEB 7, 1958	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24b. REGISTRAR'S SIGNATURE John Schuck	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2245 CERTIFICATE OF DEATH

02225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 16 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		d. STREET ADDRESS 641		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) George Daniel Sampson		First George	Middle Daniel	Last SAMPSON	4. DATE OF DEATH February 14, 1958	Month February	Day 14	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 77 yrs.	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George David Sampson		14. MOTHER'S MAIDEN NAME Siedenstricker						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Harold L. Sampson		12301 Fernmont Lane Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days		
						Arteriosclerosis years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease - Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerotic Heart Disease - Hypertension						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Olney, Maryland		20f. (City or town) Suitland, Md.		(County) Calvert (State) Md.
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE Kirchard A. Yates						ADDRESS (Street, city or town, state) Olney, Maryland		
PHYSICIAN'S NAME (Type) R. A. Yates, M. D.						DATE SIGNED 2/15/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 17, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Suitland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home.		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE 2/21/58		24b. REGISTRAR'S SIGNATURE John J. Sullivan		

REPLICA V. 2
FEB 2000
ECC-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2246 CERTIFICATE OF DEATH

02226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		d. STREET ADDRESS 5320 CHILLUM PL. N.E.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First SALVATORE		Middle	4. DATE OF DEATH SCALCO	Month 2	Day 23	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/7/81	9. AGE (In years last birthday) yrs. 76	11. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Rito Scalco		14. MOTHER'S MAIDEN NAME Josephine Marino						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Rito Scalco		5320 Chillum Place N.E. Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Atrial fibrillation DUE TO (c) Cystic sclerosis, severe, generalized					INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb. 20, 1958 to Feb. 23, 1958 that I last saw the deceased alive on Feb. 23, 1958 , and that death occurred at 8:05 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Robert J Thibadeau M.D.					ADDRESS (Street, city or town, state) 1609 Concord St. 2-2558	DATE SIGNED 2-25-58
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR FEB 26 '58		24b. REGISTRAR'S SIGNATURE Robert J. Thibadeau		

BUFILE N. 1
FEB 1953
BUFILE N. 1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12227)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 14, Film Grade 10/58 fcy		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4807 Chevy Chase Dr.</i>		e. STREET ADDRESS <i>4807 Chevy Chase Dr</i>	
3. NAME OF DECEASED (Type or print) <i>Leon Joseph Segal</i>		4. DATE OF DEATH Month Day Year <i>Feb 5 1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-18-98</i>	
9. AGE (in years last birthday) <i>59 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Translator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Dept</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>M.S.A</i>	
13. FATHER'S NAME <i>Mordecai Segal</i>		14. MOTHER'S MAIDEN NAME <i>Dora Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Bernard Segal, Silver Spring, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) [a], stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		DATE SIGNED <i>2-5-58</i>	
22d. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22e. DATE THEREOF <i>Feb 6, 1958</i>	
22f. NAME OF CEMETERY OR CREMATORIUM <i>Oaks Memorial Cemetery</i>		22g. LOCATION (City, town, or county) (State) <i>Washington - D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Danzansky & Sons</i>		ADDRESS <i>2501-14th St N.W.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 7 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Well done!</i>	

BUREAU Y. S.

EEB 7 153

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 1
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03590		
2248 CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 6 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hosp.					d. STREET ADDRESS Box 56					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First EDNA	Middle GERTRUDE	Last SHAW	4. DATE OF DEATH February 21 1958	Month	Day	Year				
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/82			9. AGE (In years less birthday) 15 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tyson Baker					14. MOTHER'S MAIDEN NAME Edith Sullivan					Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO none			17. INFORMANT Hospital records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Edema Coronary Heart Disease Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 wks. 8 yrs. years												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Olney (County) Maryland (State) M.D.				
21. I certify that I attended the deceased from 1948 , to Feb 21 , 1958, that I last saw the deceased alive on Feb. 21 , 1958, and that death occurred at Olney, Maryland , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Richard A. Yates M.D. DATE SIGNED 2-21-58 (3-21-58)												
NAME (Type) Richard A. Yates, M.D.			22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MD.									
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22f. DATE THEREOF 2/26/58		22g. NAME OF CEMETERY OR CREMATORIUM COLESVILLE CEMETERY			22h. REG'D BY REGISTRAR DATE MAR 26 '58					
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, SILVER SPRING, MD.												

Replacement certificate - Original lost
in mail 3/26/18 - MB

BUREAU V. S
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2249 CERTIFICATE OF DEATH

Reg. Dist. No. 112228

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
Montgomery				a. STATE	Md.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	Howard
Olney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Montgomery County General Hosp.					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		S	W	Lillian Conwell Shillinger	Month Feb Day 12 Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 68 yrs.
F		Wh		12/16/89	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph D. Conwell		Mary Joyce		U. S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>If yes, or unknown</small>		16. SOCIAL SECURITY NO.		17. INFORMANT	
unk				J. E. Shillinger - husband	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 nd Myocardial Infarction			
4 DUE TO		20 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary Artery Disease			
DUE TO		3 mos.			
(c) Arteriosclerosis		years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Diabetes Mellitus.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Olney, Md. (County) (State)	
21. I certify that I attended the deceased from alive on		1950, to Feb 12, 1958, that I last saw the deceased alive on Feb 12, 1958, and that death occurred at 9:40 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) Richard A. Yates M.D. Olney, Md.			
PHYSICIAN'S NAME (Type)		DATE SIGNED Richard A. YATES 2/12/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		2-17-58		Arlington National Cemetery, Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
E. CHIGWADIAH, Elliott City Md.				24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 15M 9/55				DATE	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2250 CERTIFICATE OF DEATH

112229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		d. STREET ADDRESS Rt. #1 Norwood Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Owen	Middle Witlynn	Last Shoemaker	4. DATE OF DEATH February 24	Month 24	Day 19	Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/84	9. AGE (In years lost birthday) 73 yrs	IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME William Shoemaker								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-3397		17. INFORMANT Flora Shoemaker		Address same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiac</i> DUE TO <i>Vascular Disease</i> Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Congestive Heart Failure</i> DUE TO <i>Cardiac Arrest</i> (c) <i>6 years</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month a. ft. 19	Day Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Gaithersburg	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from <i>January 24, 1958</i> to <i>Feb. 24, 1958</i> , that I last saw the deceased alive on <i>Jan. 23, 1958</i> , and that death occurred at <i>Maryland</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Maryland								
DATE SIGNED <i>2-24-58</i>								
ACTUAL SIGNATURE <i>Jack Schumacher</i> M.D.								
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Fred Memorial Park		22d. LOCATION (City, town, or county) Frederick, Maryland		
(State) Maryland								
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland								
ADDRESS Robert A. Pumphrey Bethesda, Maryland								
24a. REC'D BY REGISTRAR DATE Feb 26 '58								
24b. REGISTRAR'S SIGNATURE <i>John Schumacher</i>								

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180000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2251 CERTIFICATE OF DEATH

Reg. Dist. No.

02230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 118 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Peter	Middle P.	Last Sintetos
4. DATE OF DEATH	Month February	Day 24, 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1890
9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Liquor Business	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Panagiotis Sintetos		14. MOTHER'S MAIDEN NAME Margaret Colofiras	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. 579-03-3656	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PERITONITIS; EMPYEMA OF GALLBLADDER			
180 X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RENAL CELL CARCINOMA METASTATIC TO BRAIN, HEART, LUNGS, SPINE, LYMPH NODES			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 30, 1957 , to February 24, 1958 , that I last saw the deceased alive on February 24, 1958 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward W. Moore</i>		M.D. The Clinical Center ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 2-25-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/27/58	
22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Lumpkey</i>		ADDRESS SILVER SPRING, MD.	
		24a. REC'D BY REGISTRAR DATE FEB 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

Wiley V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Norbeck	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Norbeck/RFD/Silver Spring, d STREET ADDRESS RURAL -- Cabin John	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Motley Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Raymond	Middle Clyde	Last Sipes
4. DATE OF DEATH February 14 1958	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1892
9. AGE (In years from birthdate) 65 yrs		10. IF UNDER 1 YEAR Months 11 Days 9 Hours 0 Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John H. Sipes		14. MOTHER'S MAIDEN NAME Elizabeth Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT John T. Sipes 6510-78th St. Cabin John
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 096.9		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Complicating Intestinal Virus 5 days	
DUE TO Emphysema & Cardiorenal Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiplegia. Dementia. Bilateral Inguinal Herniae.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ Dec. 23, 1957, to Feb. 14, 1958, that I last saw the deceased alive on Feb. 14, 1958, and that death occurred at 4:45 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Norbeck, RFD Silver Spring, Md. 20910 DATE SIGNED 1/21/58	
ACTUAL SIGNATURE Webster Sewell, M.D. PHYSICIAN'S NAME (Type)		22d LOCATION (City, town, or county) (State) Potomac, Maryland	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial 2/22/58		22c. NAME OF CEMETERY OR CREMATORIAL Potomac Church	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 24 '58	
		24b. REGISTRAR'S SIGNATURE A. L. Sease	

BUREAU V. S.

Feb 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2253

CERTIFICATE OF DEATH

Reg. Dist. No.

02232

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 1 YEAR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE 13111 VALLEYWOOD		d. STREET ADDRESS 13111 VALLEYWOOD DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First SEANNE	Middle DUDLEY	Last SMITH	4. DATE OF DEATH 2	Month 6	Day 19	Year 58
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/68	9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) AMERICA, VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARCELLUS MAXS		14. MOTHER'S MAIDEN NAME MARTHA JRUGGS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Mrs. Joseph A. Fried, 13,111 Valleywood Dr.		Addressee Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 442X		(b) ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE.					
DUE TO							
DUE TO							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONGESTIVE HEART FAILURE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Day Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 10011 GEORGIA AVE	(County) SILVER SPRING, MD
21. I certify that I attended the deceased from FEBRUARY, 1957, to 2/5 , 1958, that I last saw the deceased alive on 15 , 1958, and that death occurred at 10:30 AM , from the causes and on the date stated above.						DATE SIGNED 2/6/58	
ACTUAL SIGNATURE Henry W. Stout MD		ADDRESS SILVER SPRING, MD					
PHYSICIAN'S NAME (Type) HENRY W. STOUT MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/8/58		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. RECD. BY REGISTRAR FEB 10 1958		24b. REGISTRAR'S SIGNATURE John J. Lauch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

3 10 1953

SEARCHED
INDEXED
SERIALIZED
FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2254 CERTIFICATE OF DEATH

112233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Onley	c. LENGTH OF STAY IN lb 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery Co. General Hosp.		d. STREET ADDRESS Woodbine, R.F.D. # 2	
3. NAME OF DECEASED (Type or print)	OLIVER ^{First} MIDDLE PERRY ^{Middle} SNYDER ^{Last}	4. DATE OF DEATH February	Month 9 Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31 1874
9. AGE (in years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Oliver P. Snyder		14. MOTHER'S MAIDEN NAME Annie Mary Hilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Annie M. Hilton Same AS 2 Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Pulmonary embolus INTERVAL BETWEEN ONSET AND DEATH imminess	
(b) DUE TO Gliocarcinoma of prostate		7 years	
(c) DUE TO Anterior sclerotic cardiovascular disease		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 16, 1949, to February 9, 1958, that I last saw the deceased alive on February 8, 1958, and that death occurred at M, from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kerr M.D. ADDRESS (Street, city or town, state) Physician's Name (Type) James P. Kerr Damacus, Md. DATE SIGNED Feb. 9			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. II 58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet	22d. LOCATION (City, town, or county) (State) Frederick Md.
23. FUNERAL DIRECTOR'S SIGNATURE Royce Barber		ADDRESS Laytonsville, Md.	24a. REC'D BY REGISTRAR DATE FEB 11 '58
		24b. REGISTRAR'S SIGNATURE C. L. J.	

PURNAU V. S

FEB 11 1960

LIBRARY
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2255

CERTIFICATE OF DEATH

112234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. STREET ADDRESS <i>14 W. Irving</i>					
3. NAME OF DECEASED (Type or print) <i>Thomas Alonso Snyder</i>		4. DATE OF DEATH <i>Feb 13 1958</i>	Month Day Year Feb 13 1958				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>September 4, 1888</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>					
10c. BIRTHPLACE (State or foreign country) <i>W. Virginia</i>		11. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>					
13. FATHER'S NAME <i>William E. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Isis Ingelly Woodford</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Army</i>		16. SOCIAL SECURITY NO. —					
17. INFORMANT <i>Miss Esther Anne Snyder</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>527.1</i> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary Hypertension - Right heart failure Obstructive Emphysema and Bronchitis</i>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>22 February, 1958</i> to <i>27 February, 1958</i> , that I last saw the deceased alive on <i>27 February, 1958</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>Suite 400, 8218 Wisconsin Ave.</i>		DATE SIGNED <i>2/29/58.</i>			
ACTUAL SIGNATURE <i>Edward S. Witowski, Jr.</i>		PHYSICIAN'S NAME (Type) <i>EDWARD S. WITOWSKI, JR.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>3/3/1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>7557 Wis. Ave. Bethesda, Md.</i>		24a. REC'D BY REGISTRAR d. DATE <i>V.A. 3 3/3</i>	24b. REGISTRAR'S SIGNATURE <i>G. L. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 3 1960

BUREAU V. S.

112235

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

I
1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
o. STATE Maryland b. COUNTY Montgomery

3. NAME OF DECEASED
(Type or print) First Middle Last

4. DATE OF DEATH Month Day Year

5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

9. AGE (in years
from birthday)
73 yrs.
IF UNDER 1 YEAR
Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY Private family

11. BIRTHPLACE (State or foreign country)
Charlottesville, Virginia

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME Jack Sparks

14. MOTHER'S MAIDEN NAME ? Deanie

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 17. INFORMANT

Address 34 Morningside Ave
Mrs. Walter Jenkins-sister New York 26, N. Y.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, If any, which gave rise to immediate cause (b)
(a), stating the underlying cause lost.
DUE TO
(c)

INTERVAL BETWEEN
ONSET AND DEATH
found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma of throat for two years

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

2. MEDICAL CERTIFICATION

ACTUAL SIGNATURE Frank J. Broschart

DATE SIGNED

EXAMINER'S NAME (Type) Frank J. Broschart, M. D.

M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, OR REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Removal 2/25/1958 McGuire Funeral Home Washington Dist. Col.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md. FEB 27 '58 *Levine*

VII. A15ME
SM 2/57

1958

СЕВАСТОПОЛЬ

СЕВАСТОПОЛЬ

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

112236

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2709 Fenimore Rd.		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward W Steers		First	Middle
4. DATE OF DEATH	Month	Day	Year
Feb. 16, 1958	19		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1900
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. W. Steers		14. MOTHER'S MAIDEN NAME Whitner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. <i>WWI</i>	
17. INFORMANT		Address	
Pauline E. Steers (wife)		Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH sudden	
Coronary Occlusion			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 2/17/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery 254 Carroll St NW DC		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		24a. REC'D BY REGISTRAR FEB 18 '58	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. M.

1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

112237

FOR STATE
HEALTH DEPT.

TO MEDICAL EXAMINER: This cert'ficate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained at your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 '57

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hospital, Inc.		e. STREET ADDRESS Baltimore	
3. NAME OF DECEASED (Type or print) Elva		4. DATE OF DEATH February 4 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1909	
9. AGE (in years from birthday) 48		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Hurwitz	
14. MOTHER'S MAIDEN NAME Lena Davidson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Isabore Goldberg, 1022 Quebec Ter. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage		19. INTERVAL BETWEEN ONSET AND DEATH 25 minutes	
DUE TO Conditions, if, any, which gave rise to immediate cause (a), stating the underlying cause first. crushed chest			
(b) DUE TO Cause lost. auto accident			
(c) DUE TO Cause lost. auto accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of jaw, left and fracture of left ankle.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was passenger in car involved in auto accident.	
20c. TIME OF INJURY Hour 3:00 p.m. Month, Day, Year 2/4/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. R. 29, Burtonsville Montg. Md.	
20f. (City or town) Burtonsville		(County) Montgomery	
(State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE Frank J. Broschart	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58	
22c. NAME OF CEMETERY OR CREMATORIAL United Hebrew		22d. LOCATION (City, town, or county) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE FEB 7 '58	
		24b. REGISTRAR'S SIGNATURE W. L. Smith	

Y. 8

3 103

GENERAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2259

CERTIFICATE OF DEATH

Reg. Dist. No.

112238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1914 Stratton Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) CLARINDA CROUTE STOUT		d. STREET ADDRESS 1914 Stratton Road	
4. DATE OF DEATH February 4, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 8, 1876
		9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (State or foreign country) Olney, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Croutte		14. MOTHER'S MAIDEN NAME Malinda Lilly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Mrs Marion H. Stout, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH 11 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Cerebral thrombosis	
DUE TO (c)		Arteriosclerosis - Generalized 10 years + Cerebral -	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 1956, to Feb 4, 1958, that I last saw the deceased alive on Feb 4, 1958, and that death occurred at 10:15 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Gates Park, Maryland DATE SIGNED Feb 4, 1958	
ACTUAL SIGNATURE <i>Joseph H. Watson</i>		PHYSICIAN'S NAME (Type) M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/7/58	
22c. NAME OF CEMETERY OR CREMATORIAL 1756 Pennsylvania Ave NW, Washington, D.C.		22d. LOCATION (City, town, or county) Interlaken, New York (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph H. Watson</i>		24a. REC'D. BY REGISTRAR FEB 6 '58 DATE	
VS AJS (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE <i>Allesbach</i>	

LIBRARY V. 2

FEB 6 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02239
Item 7 Fi 5-7-58										
2260 CERTIFICATE OF DEATH										Reg. Dist. No. 215
1. PLACE OF DEATH a. COUNTY Montgomery					b. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN lb 77 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMC, Bethesda Md.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Albert	Last TALLMAN	4. DATE OF DEATH February 1 1958	Month February	Day 1	Year 1958		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 December 1879	9. AGE (In years lost birthday) 77 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			11. BIRTHPLACE (State or foreign country) Alabama			12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Richard P. TALLMAN			14. MOTHER'S MAIDEN NAME Mary DELACY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Sp. Am. WW-II & I			16. SOCIAL SECURITY NO. Unknown			17. EMPLOYER (Official Navy Records)			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 11119 DUE TO Carcinoma, Squamous cell, Tongue Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 yrs (approx.)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from 16 November, 1957, to 1 February, 1958, that I last saw the deceased alive on 1 February, 1958, and that death occurred at 9:15A.M. from the causes and on the date stated above. ACTUAL SIGNATURE: 16. C. Shea M.D. U.S. Naval Hospital, Bethesda, Md. 2-3-58										ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) M.C. SHEA, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery			22d. LOCATION (City, town, or county) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.					24a. REC'D BY REGISTRAR FEB 6 '58					
					24b. REGISTRAR'S SIGNATURE D. J. C. /					

REGELVÉD

FEB. 6, 1962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02240

2261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Sp.		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8668 Piney Branch Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Silver Spring, Apt. T4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Askins	Last Thornton	4. DATE OF DEATH	Month February	Day 23	Year 1958
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 2, 1902	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY family		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elliot Askins		14. MOTHER'S MAIDEN NAME Agnes Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Frances Johnson		8668 Garfield Ave., Takoma Park, Md. T4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 732X		DUE TO Hypertension					
{ (b)		DUE TO Arteriosclerotic Disease					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 1934, to Feb. 23, 1958, that I last saw the deceased alive on Feb. 23, 1958, and that death occurred at 10:07 A.M. from the causes and on the date stated above.				P ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Webster Sewell		M.D.		Norbeck Rt. 1 Silver Sp., Md.			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.							
22a. BURIAL, CREMATION, BURIED <input checked="" type="checkbox"/> (Specify)		22b. DATE THEREOF 2/27/58		22c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial		22d. LOCATION (City, town, or county) Sandy Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Givens		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAR 3 '58		24b. REGISTRAR'S SIGNATURE Givens	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A MAY

EST 18

3 A MAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12241)

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This cert' cate should be executed in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH a. COUNTY		2262		Reg. Dist. No.	
Montgomery		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 12 yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring				Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2913 Stanton Ave.		2913 Stanton Ave		g. DATE OF DEATH Feb. 18, 1958	
h. NAME OF DECEASED (Type or print)		First	Middle	Month	Doy
Robert Kelley Thulman				Feb.	18
i. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 12/31/1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
engineer (mechanical)		Chimney Sales Corp.		N.J.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John A. Thulman		Mary M. Kelley		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address	
Yes		WW #1 220-32-6316		Katherine D. Thulman (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH sudden			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____			
		(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/19/58	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/22/58		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren & Lumpfrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE FEB 24 '58	
				24b. REGISTRAR'S SIGNATURE <i>Q. L. ...</i>	

BUREAU N.Y.

FEB 6 4 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2118 CERTIFICATE OF DEATH

Reg. Dist. No.

02242

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1105 Kirklynn Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle M.	Last THURMAN
4. DATE OF DEATH	Month FEB. 18		Day 19
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/73
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER & FARMER		10b. KIND OF BUSINESS OR INDUSTRY TUNNEL, OHIO	
11. BIRTHPLACE (State or foreign country) TUNNEL, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID THURMAN		14. MOTHER'S MAIDEN NAME EMILE LONGFELLOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-14-7131	
17. INFORMANT Mr. Arthur E. Housman, 1105 Kirklynn Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Takoma Park, Maryland <i>Arterio-Sclerotic Heart Disease</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/12 , 19 77 , to 2/18 , 19 58 , that I last saw the deceased alive on 2/18/58 , 19 58 , and that death occurred at 4:23 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 113 Carroll St. NW, Wash. D.C.	
ACTUAL SIGNATURE <i>Dean H. Hardinge</i>		DATE SIGNED 2/19/58	
PHYSICIAN'S NAME (Type) DEAN H. HARDING		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/22/58	
22c. NAME OF CEMETERY OR CREMATORIUM UNION CEMETERY		22d. LOCATION (City, town, or county) BURTONSVILLE, MONTGOMERY CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter G. Humphrey,</i>		24a. REC'D. BY REGISTRAR DATE FEB 24 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE <i>St. Neale</i>	

BUREAU Y

1958

REVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2263

CERTIFICATE OF DEATH

Reg. Dist. No. 215

02243

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY	
c. LENGTH OF STAY IN lb 1 hr. 4 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	Last TOWNSEND	4. DATE OF DEATH Month February	Doy 7	Year 1958
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5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 7 February 1958	9. AGE (In years last birthday) yrs. Months Days Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.
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13. FATHER'S NAME Edward Francis TOWNSEND	14. MOTHER'S MAIDEN NAME Mary Jane ECKEL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT (Father) Edward F. Townsend (Same As #2)	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) { DUE TO (c) <i>Eight rib fractures, facial (hydrocephalus)</i>		1 hr. 4 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 February 1958 to 7 February 1958, that I last saw the deceased alive on 7 February 1958, and that death occurred at 10:05A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE *Louis Miller, Jr. M.D.* M.D. U.S. Naval Hospital, Bethesda, Md. 2-7-58

PHYSICIAN'S NAME (Type) RUSSELL MILLER, JR. LT, MC, USN	U.S. Naval Hospital, Bethesda, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-8-58	22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Virginia
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23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Lummus</i>	ADDRESS Wisconsin Ave., Bethesda, Md.	24a. REC'D BY REGISTRAR FEB 10 '58	24b. REGISTRAR'S SIGNATURE <i>Asst. Registrar</i>
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BUREAU Y. S.

13 10 1953

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2119

CERTIFICATE OF DEATH

Reg. Dist. No.

02244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>7½ days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>James</i>		First	Middle	Last	4. DATE OF DEATH <i>February 15 1958</i>	Month	Day	Year		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>February 7, 1958</i>	9. AGE (In years lost birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>7</i>	IF UNDER 24 HRS Days <i>15</i>	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>William Harvey Vaughn</i>		14. MOTHER'S MAIDEN NAME <i>Avenel Bright</i>		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Pt.s chart</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i>			INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>11.3.5</i>		DUE TO (b)		Probable hyaline membrane disease						
		DUE TO (c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Washington Sanitarium & Hospital Takoma Park</i>	20f. (City or town) <i>Takoma Park</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>Feb 7</i> , 1958, to <i>Feb 15</i> , 1958, that I last saw the deceased alive on <i>Feby 15</i> , 1958, and that death occurred at <i>12:02 AM</i> , from the causes and on the date stated above									ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Winston E. Cochran</i>	M.D.									
PHYSICIAN'S NAME (Type) <i>Winston E. Cochran, M.D.</i>	927 Pershing Drive, Silver Spring, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>3-2-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington Sanitarium & Hospital</i>		22d. LOCATION (City, town, or county) <i>Takoma Park</i>		(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Herx, Jr.</i>	ADDRESS <i>Wash. San. & Hospital</i>	24a. REC'D BY REGISTRAR <i>Mar 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Lewis</i>						

Y. K. RIVKIN
200 2 2
Rivkin

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2264 CERTIFICATE OF DEATH

Reg. Dist. No. 02245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Boyds	
3. NAME OF DECEASED (Type or print) Courtney		First Anne	Middle Wade
4. DATE OF DEATH February 20, 1958		Month February	Day 20
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH November 7, 1890		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Allen H. Burdette	
14. MOTHER'S MAIDEN NAME Nellie Bosley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-34-9182		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 DUE TO <i>Malignant melanoma</i> INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 24, 1958 , to February 20, 1958 , that I last saw the deceased alive on February 20, 1958 , and that death occurred at 3:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Kurt W. Kohn PHYSICIAN'S NAME (Type) Kurt W. Kohn, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/58	22c. NAME OF CEMETERY OR CREMATORIAL Monocacy
22d. LOCATION (City, town, or county) Bowieville		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DATE FEB 25 '58	24b. REGISTRAR'S SIGNATURE Annesia

BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2120

CERTIFICATE OF DEATH

Reg. Dist. No.

112246

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN MD <i>24-50 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>76 Silver Spring</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Lutonium and Hosp.</i>		d. STREET ADDRESS <i>12217 Bladhill Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First	Middle <i>Henry</i>	Last <i>Walker</i>	4. DATE OF DEATH <i>Feb - 9 1958</i>	Month	Day	Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-24-09</i>		9. AGE (In years last birthday) <i>48 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>plumbing</i>		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Austin Walker</i>		14. MOTHER'S MAIDEN NAME <i>Blanche Sandester</i>				Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO <i>W.W. 2</i>		17. INFORMANT <i>Hospital Records</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416X</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		<i>CEREBRAL INFARCTION</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>No</i>		DUE TO <i>EMBOLIZATION RT CAROTID Artery (?)</i>		<i>RHEUMATIC HEART DISEASE 10 YRS</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>OCT 10, 1953 to Oct 19, 1954</i>		(County) <i>Baltimore</i> (State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Oct 10, 1953 to Oct 19, 1954</i> alive on <i>2/8</i> , and that death occurred at <i>3:00 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>1352 UNIVERSITY</i>		DATE SIGNED <i>1352 UNIVERSITY</i>
ACTUAL SIGNATURE <i>Donald Shulz</i>		M.D.		PHYSICIAN'S NAME (Type) <i>Harold STEEL, N.C. 13</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/12/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Natl. Cem.</i>		22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Hines</i>		ADDRESS <i>1030 1/2 D.C. 2901 1/4 th St. NW</i>		24a. REC'D BY REGISTRAR <i>FER 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Deborah</i>		

BUREAU Y. S.

3 - 1963

JOHNSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2463

CERTIFICATE OF DEATH

02247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] a. STATE	
<i>Montgomery Co., Maryland</i>		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print)		First <i>Bernard</i>	Middle <i>E.</i>
4. DATE OF DEATH		Last <i>Walls, Sr.</i>	Month <i>February</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years last birthday) <i>62 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept.</i>	11. BIRTHPLACE (State or foreign country) <i>Govt. Employees Wash. D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Bernard Walls</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Ebert</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	
16. SOCIAL SECURITY NO <i>WW # 1</i>		17. INFORMANT <i>Bernard E. Walls Jr. (Same) Son</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>	
4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Congestive Heart Failure</i> <i>Myocardial Infarction</i> <i>Coronary Artery Occlusion</i> <i>48 hrs</i> <i>48 hrs</i> <i>48 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Old myocardial Infarct - Osmic</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> , to <i>2 Feb</i> , <i>1958</i> , that I last saw the deceased alive on <i>2 Feb</i> , <i>1958</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Merton L. White</i>		ADDRESS (Street, city or town, state) <i>1613 1/2 Georgia Ave NW 20037</i>	
PHYSICIAN'S NAME (Type) <i>MERTON L. WHITE</i>		DATE SIGNED <i>10/13/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>2/6/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>ARLINGTON NAT'L CEMETERY</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON, VIRGINIA</i>	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren L. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Debt due</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it is to be filed with page 3 showing the name of the funeral director. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEAU V.

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02248

: 2464 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Maryland - Montgomery MARYLAND		a. STATE Maryland	b. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None - 9216 Flower Ave.		d. STREET ADDRESS 9216 Flower Avenue	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary	Middle Walker
		Last Walton	4. DATE OF DEATH Feb. 20, 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Dec. 10, 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Brunswick, Georgia
		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Timothy W. Dexter		14. MOTHER'S MAIDEN NAME Ida Morton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Isobel G. Dexter - Sister Silver Sp. M.
		Address 9216 Flower A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Parkinson disease. 2. Intercardiac heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1948</u> to <u>22 Sept. 1958</u> , that I last saw the deceased alive on <u>19 Feb. 1958</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Joseph T. Kimble</u> M.D. <u>929 Parkview Drive, Silver Spring, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Feb. 20, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 20, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Ch. of Our Saviour</u>
		22d. LOCATION (City, town, or county) <u>Rio, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons</u>		ADDRESS <u>Joseph Gawler's Sons - Washington, D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 23 1958</u>
		24b. REGISTRAR'S SIGNATURE <u>John L. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GUEREAU V. S.

3
62

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2465

CERTIFICATE OF DEATH

(12249)

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 1 yr. 10 mo.	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 3311 McElderry Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eva	Middle Christine	Last WATSON
4. DATE OF DEATH Feb 15 1958	Month	Day	Year
5. SEX Female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1887
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John F. Bishop		14. MOTHER'S MAIDEN NAME Virginia Lighthouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-34-1413	17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <u>arricular fibrillation</u> (c) <u>cardio vascular disease + hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unmed off + on 1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-5</u> , 19 <u>56</u> , to <u>2-15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>58</u> , and that death occurred at <u>8:32 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D. ADDRESS (Street, city or town, state) <u>4308 Anthony St, Kensington, Md.</u> DATE SIGNED <u>2-15-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Inyment</u>		22b. DATE THEREOF <u>2/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shm. J. Zichner & Sons - Balt. 17</u>		ADDRESS <u>100 E. Pratt St., Baltimore, Md.</u>	
		24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Albertine</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Y. A. SOUTHERN

1000 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Pa.	
Rockville		one day		e. COUNTY Allegheny	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Pittsburgh 21		f. IS PERTINENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
811 E. Jefferson St.		152 Ave. A., Forrest Hills			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Thomas Raymond Watts					Feb. 15, 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years Ind by Major) 62 59 yrs
male white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11/25/1897	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Elec. engineer				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Thomas M. Watts		Blanche Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
(If yes, give war or dates of service)		169-09-6232		Ray.D. Watts Sames Item 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, If any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/16/58	
EXAMINER'S NAME (Type) Frank J. Broschart		22a. DATE THEREOF 2/19/58			
22b. BURIAL, CREMATION (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORIUM Jefferson Memorial Park		22d. LOCATION (City, town, or county) Wilkensburg, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR DATE FEB 20 '58 24b. REGISTRAR'S SIGNATURE <i>Alfredusen</i>	

BUREAU V.

FEB 20 1969

LIBRARY

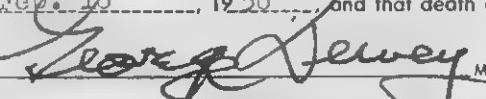
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02251

Reg. Dist. No.

2466

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE								
Montgomery				Washington, D.C.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
Kensington		2 mos.		Wash 6 D.C.								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
Kensington Gardens, 3000 McComas Ave		1812 K St., N.W.										
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
	Anna	A	Whitman	8/23/68	February	18	19	58				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 89?	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min				
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8/23/68 ?	89?								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)							12. CITIZEN OF WHAT COUNTRY?	
Social Secretary			Clerical	Eric, Penna							U.S.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address				Kensington, Md.
no						Rest Home Records-3000 McComas Ave.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis												3½ yrs
4x2.1 DUE TO												
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis												11 yrs
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Fracture, left hip, Nov. 30, 1957, repaired same day Drs. Hosp												Wash DC
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)										
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		Slipped on rug on way to front door to get morning paper										
20c. TIME OF INJURY 10 Hour a.m. 11/30/57 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
				Home		1312 K St., N.J. Wash 6 DC						
21. I certify that I attended the deceased from April 2 1946, to Feb. 18 1958, that I last saw the deceased alive on Feb. 18, 1958, and that death occurred at 3:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)												DATE SIGNED
George Dewey M.D. 1622 Columbia Road, N.W. Wash 9 DC 2/18/58												
ACTUAL SIGNATURE												
PHYSICIAN'S NAME (Type)		George Dewey, M.D.										
22a. BURIAL, CREMATION, REMOVAL (SPECIFY)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
Removal		2/21/58		Erie Cemetery		Erie, Pennsylvania						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE						
The S. H. Hines Co. Washington, D. C.		The S. H. Hines Co. Washington, D. C.		FEB 24 58		John Allen						

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU W. S.

FEB 24 1958

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2467

CERTIFICATE OF DEATH

Reg. Dist. No.

(12252)

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington-Rural		c. LENGTH OF STAY IN lb 5 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Peeblesville		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Capital View Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances Peele Williams	First	Middle	Last	4. DATE OF DEATH FEB 8 1958	Month	Day	Year
5. SEX XMK Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 78 Feb 2-1887	9. AGE (In years last birthday) 30 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Peeblesville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME Richard Peele				14. MOTHER'S MAIDEN NAME Florence Peele			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William Williams, 7007-Delaware St., Chevy Chase, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Broncho pneumonia DUE TO (c) Cerebral Thrombosis							
INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4 , 1958, to Feb 7 , 1958, that I last saw the deceased alive on Feb 7 , 1958, and that death occurred at 1:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Robert J. Trudeau, M.D. ADDRESS (Street, city or town, state) 16609 CONCORD ST. DATE SIGNED Feb 8-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 10-1958		22c. NAME OF CEMETERY OR CREMATORIUM Monocacy		22d. LOCATION (City, town, or county) (State) Peeblesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton				ADDRESS Barneville		24a. REC'D BY REGISTRAR DATE FEB 11 '58	
						24b. REGISTRAR'S SIGNATURE Robert J. Trudeau	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

FEB 11 1958

WISCONSIN
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2121

CERTIFICATE OF DEATH

Reg. Dist. No.

112253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN Tb <i>9 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. + Hosp.</i>		d. STREET ADDRESS <i>12308 Dewey Road</i>		e. DATE OF DEATH Month <i>Feb. 19</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF (Type or print) <i>Harry John Wilson</i>		First	Middle	Last	Year <i>1958</i>	Day	Month				
4. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-22-92</i>	9. AGE (In years last birthday) yrs. <i>65</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retired</i>		11. BIRTHPLACE (State or foreign country) <i>Mich.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>					
13. FATHER'S NAME <i>Joel A. Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Maneri Laurena</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-03-1769</i>					
17. INFORMANT <i>Chark</i>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal obstruction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) Metastatic Carcinoma Generalized 7 mos.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Feb. 10, 1958</i> , to <i>Feb. 19, 1958</i> , that I last saw the deceased alive on <i>Feb. 19, 1958</i> , and that death occurred at <i>6:45 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave. 211958</i>		DATE SIGNED							
ACTUAL SIGNATURE <i>Paul V. Starr M.D.</i>		PHYSICIAN'S NAME (Type) <i>Paul V. Starr</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2/24/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MONTGOMERY COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm E Lemphay</i>		ADDRESS <i>1117 Silver Spring, MD 20910</i>		24a. REC'D BY REGISTRAR <i>FEB 25 54</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. E. Lemphay</i>					

8. V. A. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112254

2468 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>	c. LENGTH OF STAY IN lb <i>Suburban Hospital</i>	b. COUNTY <i>MONTGOMERY</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WESTMORE ROAD</i>		d. STREET ADDRESS <i>KARL ANTHONY WILSON</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>KARL</i>	Middle <i>ANTHONY</i>	Last <i>WILSON</i>		
4. DATE OF DEATH <i>FEBRUARY 10, 1958</i>	Month <i>February</i>	Day <i>10</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 8 1958</i>		
9. AGE (In years from birthday) yrs. <i>2</i>	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS. Days <i>2</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>G. S. A.</i>		
13. FATHER'S NAME <i>CORNELIUS EDWARD WILSON</i>	14. MOTHER'S MAIDEN NAME <i>Mariet LORETTA MATTHEW</i>	Address <i>Mother</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>—</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1.5</i> DUE TO <i>Chronic Emphysema</i> Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. <i>—</i> DUE TO <i>—</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Inhalation Anesthesia due to premature separation of placenta</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> <i>Not while at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bethesda</i>	20f. (City or town) <i>Bethesda</i>	(County) <i>Maryland</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>10 Feb 1958</i> to <i>10 Feb 1958</i> , that I last saw the deceased alive on <i>10 Feb 1958</i> , and that death occurred at <i>135 P</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.H. MITCHELL</i>	M.D. <i>R.H. MITCHELL</i>	ADDRESS (Street, city or town, state) <i>8318 Wisconsin Ave</i>	DATE SIGNED <i>11 Feb 58</i>		
22a. BURIAL, CREMATION, BURIAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/12/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lincoln Park,</i>	22d. LOCATION (If not in item 22c, enter separately) <i>ROCKVILLE, MD.</i>	(State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Swanson</i>	ADDRESS <i>Rockville, Md</i>	24a. REC'D BY REGISTRAR DATE <i>FEB 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		

FEDERAL BUREAU OF INVESTIGATION

FEB 20 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2469

CERTIFICATE OF DEATH

112255

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 187 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coal City		d. STREET ADDRESS None	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eva	Middle Blanche	Last Withrow	4. DATE OF DEATH	Month February	Day 15	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1895	9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gordon Gray				14. MOTHER'S MAIDEN NAME Agnes Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia							
14-14 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Epidermoid carcinoma, hard palate. Extension to maxillae, nasopharynx, sphenoid and ethmoid bone. 2 yr.							
(c) DUE TO Leptomeningitis							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
411X 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. August 12, 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) The Clinical Center		20f. (City or town) (County) (State) Bethesda 14, Maryland	
21. I certify that I attended the deceased from August 12, 1957 , to February 15, 1958 , that I last saw the deceased alive on February 15, 1958 , and that death occurred at 3:00 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The National Institutes of Health							
DATE SIGNED 2/16/58							
ACTUAL SIGNATURE John R. Gill							
M.D. The Clinical Center							
PHYSICIAN'S NAME (Type) John R. Gill, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 2/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Wildwood		22d. LOCATION (City, town, or county) (State) Beckley, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE FEB 20 1958		24b. REGISTRAR'S SIGNATURE Alfred C. ...	

McGraw-Hill

EB 20 1059



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2129

CERTIFICATE OF DEATH

Reg. Dist. No.

12256

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 2 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26		d. STREET ADDRESS 4407-DANVERS' ST		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. PHILomena REST HOME Norbeck, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELIZABETH O. WOOLARD		First	Middle	Last	4. DATE OF DEATH FEB 8	Month	Day	Year 1958
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1879	9. AGE (In years lost birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME WILLIAM Sisson		14. MOTHER'S MASTERN NAME ISABELLE Ashton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 519-28-0772		17. INFORMANT J.R. Woolard		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		
						Terminal arterial occlusion INTERVAL BETWEEN ONSET AND DEATH 3 days		
						Arterial Selective Heart Disease		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 2/6 , 19 58 , to 2/8 , 19 58 , that I last saw the deceased alive on 2/6 , 19 58 , and that death occurred at 12:14 M, from the causes and on the date stated above. ACTUAL SIGNATURE Charles J. Weber PHYSICIAN'S NAME (Type) CHARLES J. WEBER								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-10-58		22c. NAME OF CEMETERY OR CREMATORIUM FT Lincoln		22d. LOCATION (City, town, or county) Bladensburg, Md (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Seal Funeral Home 4811 Harford Rd		ADDRESS Seal Funeral Home 4811 Harford Rd		24a. REC'D. BY REGISTRAR FEB 19 1958		24b. REGISTRAR'S SIGNATURE John Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DELIVERY

BUREAU V. S.

FEB 12 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(12257)

Reg. Dist. No.

2122

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Montgomery</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Takoma Park</i>		<i>Takoma Park</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
7 Hrs-15 min		6605 Quide Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Washington Sanitarium & Hospital</i>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <i>Jay</i>		Middle <i>Ormond</i>	Last <i>Wright</i>
5. SEX		6. COLOR OR RACE	
Male		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday) yrs.	
6-13-48		9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Child</i>		<i>—</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>D.C.</i>		<i>America</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Jay D. Wright Jr</i>		<i>Ruby Huffman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		<i>Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i>			
DUE TO <i>812X</i>			
(b) <i>Cerebral contusion + hemorrhage</i>			
DUE TO <i>Fracture of skull</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Rupture Zygoma. Fracture of mandible (left) & Femur at</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>7 1/2 hrs</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by car while sleeping</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>9:00</i> p.m. <i>2-17 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>street</i>		20f. (City or town) <i>Takoma Park</i> (County) <i>P.G.</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <i>2-18-58</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/20/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. H. Hines Co. Washington, D. C.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>2-20-58</i>		24b. REGISTRAR'S SIGNATURE <i>Autograph</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

BY THE GOVERNMENT OF CANADA
MEDICAL EQUIPMENT CORPORATION

BUREAU Y.
RECEIVED
FEB 20 1968